adolescent pregnancy: THE CHALLENGE

a framework for prevention and parenting

THE GOVERNOR'S TASK FORCE

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Dear Governor Brennan,

On behalf of the members of the Governor's Task Force on the Prevention of Adolescent Pregnancy and Parenting, I am pleased to present our findings and recommendations. ADOLESCENT PREGNANCY: THE CHALLENGE provides an exhaustive and definitive analysis of the problem of teenage pregnancy and parenting in Maine. We offer what we believe are the most effective ways in which Maine parents, communities, professionals, and governments can assist teens in the prevention of pregnancy.

We commend you for your concern for the quality of life of the teenagers of Maine and their families. We commend you for establishing the Task Force, involving 37 experienced and knowledgeable persons from varied backgrounds and all ages. We commend you for the challenge to study and attempt to understand the complexities involved in the experiences and lives of teenagers who become sexually active, and, far too often, pregnant and parents before they are ready to assume these responsibilities.

Task Force members worked with an excellent blend of creativity and diversity. As we faced what seemed to be a mountain of research and information, we creatively organized ourselves and worked to clarify important issues for public consideration. The diversity in the group became focused around the changes and crises taking place in family life and marriage, and sexual mores, and in the meanings and values surrounding these issues in society.

We are clear that it will take a concerted effort by all segments of Maine society to have a positive influence on adolescent development and sexual activity. It will take shared commitment from teens, family members and communities to assist teens to postpone sexual intercourse until they are mature enough to become responsible for the consequences. And, it will take an exciting blend of family, community, and government resources to help teenage parents to face their challenging new roles. Our report challenges all of us to care, and to become involved in creating a strengthened and hopeful environment for teenagers.

It has been a privilege to work with this group of caring, and committed citizens, all of whom gave much time and energy to the development of this report. I also want to express my appreciation to Michael Petit, Commissioner of the Department of Human Services and his staff, directed by Donna Overcash. It has been the hard, dedicated work of staff under difficult time constraints and circumstances that has made this report possible.

We hope you will appreciate the breadth and depth of our work, find agreement with the directions we recommend, and use the power of your office to begin the process of implementing our recommendations. ADOLESCENT PREGNANCY: THE CHALLENGE provides a framework for prevention and an exciting opportunity to explore and focus on Maine adolescents and their families. Often much gets said and little gets accomplished. Our hope rests in your initiative with this report and its implementation in the communities across the state.

Sincerely,

C. Richard Sheesley

Rev. C. Richard Sheesley, D. Min.
Chairman

the governor's task force on the prevention of adolescent pregnancy and parenting

chair

Reverend C. Richard Sheesley, D. Min.
Director of Pastoral Care
Central Maine Medical Center, Lewiston

staff

Donna Overcash, Staff Director
Alison Deming
Jacqueline Clark
Louise Johnson

members by task group

external forces

Charles M. Lyons, Ph.D., University of Maine, Co-Leader
Pamela Plumb, Portland City Council, Co-Leader
Margaret Pruitt Clark, Ph.D., National Organization for Women, Brunswick
Judy Clossey, R.N., Maine School Nurses' Association, Camden
Ray Cook, YWCA Intervention Program, Auburn
Donald J. Goodwin, Maine Secondary School Principal's Assn., Thomaston
Fred Nutter, WCSH Television, Portland
John Serrage, M.D., Department of Human Services, Augusta
C. Richard Sheesley, D. Min., Central Maine Medical Center, Lewiston
Paul Thibeault, SCABS, Maranacook Community School, Readfield
Pat Anderson, Statewide Service Providers' Coalition on Adolescent Pregnancy, Augusta
Kathy Hance, Quest Program, Gardiner Area High School
Kim Newton, SCABS, Maranacook Community School, Readfield

internal forces

Donna Bailey-Miller, Education Consultant, Wayne, Co-Leader
Reverend Gordon Svoboda, United Church of Christ, Bath, Co-Leader
Jennifer Briggs, Quest Program, Gardiner Area High School
Tammy Cook, Teen Parent Services, Portland, YWCA
Sr. Theresa Couture, St. Andre's Home, Inc., Biddeford
Reverend Thomas Davis, Littlefield Memorial Baptist Church, Rockland
Dianne Donnelly, Kennebec Girl Scout Council, Winthrop
Ruth S. Foster, State Representative, Ellsworth
Christine Franck, Teens 'N' Theater, Skowhegan
Dick Kennedy, Camp Kieve, Nobleboro
Terrance J. Sheehan, M.D., Physician, Augusta
Cary Tolman, Alternate, SCAB, Maranacook Community School, Readfield

the system

Donnell P. Carroll, State Representative, Gray, Co-Leader
Sharon Hole, South Harpswell, Co-Leader
Cynthia Baldwin, YWCA, Portland
Teri Banks, Teen Parent Services, Portland YWCA
David Birch, Department of Educational and Cultural Services, Augusta
Sabra Burdick, Department of Human Services, Augusta
Gretchen Dubay, Teens 'N' Theater, Skowhegan
Bill Gee, Lewiston Police Department
Jeanne Bailey McGowan, Family Planning Association of Maine, Augusta
Neil D. Michaud, Diocesan Human Relations Services, Portland
Cynthia Sortwell, M.D., Pediatrician, South Portland
John Zerner, M.D., American College of Obstetricians and Gynecologists, Maine Chapter, South Portland

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consultants

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special assistance
(writing and research)

Carol Wynne, Winthrop: The Idea Bank
Michael Kimball, Coopers Mills: Male Sexuality, Teen Fathers, Older Fathers, Teens Who Marry
Donna Gold, Hallowell: The Changing Family
Renee Curry, Hallowell: The American Teenager, 1945-86
Susan Sullivan, Portland: Research on Sexual Abuse and Teen Pregnancy
Elinor Multer, Owl's Head, Research, Editing, Data Interpretation

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graphic design and layout

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Kathleen Meade-Knight
Eileen Lincoln

typesetting

Black Spruce Type/Graphics, Freeport
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adolescent pregnancy: the challenge

a report of the governor's task force
a framework for prevention

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Contact: Donna Overcash
Office of Children's Policy
Department of Human Services
State House Station 11
Augusta, Maine 04333

the introduction

why is teen pregnancy a matter of public policy? why now?

There is something alarming about. . .

. . .a 13 year old girl who is pregnant,
. . .a 15 year old teenage father,
. . .an 18 year old with two children,
. . .a divorced 19 year old, and
. . .a 17 year old mother and child on AFDC.

Most of us view these young people as children.

At best they are young DEVELOPING adults — adolescents, who should be growing and learning how to fulfill responsible and productive adult roles.

The expectations for the teenager who becomes a parent too often include: a life of welfare dependency; risks of health complications; limited educational and career opportunities; the likelihood of early divorce; and a second, third or even fourth child who may become an early parent and face the same consequences as the teen.

But why is teen pregnancy a matter of public policy? Why now? It is not a new issue.

It is a social policy problem because of the medical, economic and social consequences for the teenagers, their children and their families, and because of the high costs of the programs necessary to mitigate these consequences. It is a public policy problem NOW because more and more teenagers who become pregnant choose to become single mothers which dramatically increases their chances of needing public support. It is a problem because more teenagers are getting pregnant at earlier ages than ever before. But there is more.

From 1980 to 1986, Maine studied many of the problems faced by its children and their families.

We looked at child death -- and we found that a child who lives in poverty is three times more likely to die from all causes of death than a child who is not poor.

We looked at poverty -- and we found that a family headed by a young mother is seven times more likely to live in poverty.

We looked at the current population of children enrolled in the AFDC program and found that 52% of them have a mother who gave birth to her first child in her teens.

We looked at child abuse -- and we found that 1 out of 10 families on AFDC are referred as child protective cases compared to 1 out of 100 of all other families.

Among all of the problems that these children face, one common thread links them together: the quality and degree of parenting they receive. The best start in life is to be born wanted and to begin life with parents who are prepared to provide love, nurturing, education, and the opportunity for an economically sound future. But, when low income, single parent status, and teenage parenthood are combined, the teenager and child face an endless parade of health, economic, social and personal problems throughout their lives.

And yet, more than 3000 teenagers become pregnant each year in Maine, 2000 of them give birth and more than 1100 of them start adulthood as young, single parents. These teen mothers are rarely living in families that can provide for them financially; they frequently do not finish high school; they seldom are prepared to find gainful employment; they start parenthood without the benefit of a second income from a male partner; they are, for the most part, destitute.

It is also not surprising that the young married teens face severe odds. They are more than twice as likely to divorce than marriages between partners who are in their twenties. More than 50% of the teens will face divorce, often after having yet another child while very young. This inevitably means they will join the ranks of low-income, single mothers.

Teenage pregnancy is preventable. The medical model tells us that prevention is cost effective. For every $1.00 spent on preventive health care, it is estimated that more than $8.00 can be saved on the treatment of a health problem. Estimates of the cost of effective contraceptives show a more conservative 2.2 to 1 cost savings that occurs when a pregnancy is prevented and the high costs of teen parenting are avoided.

Prevention initiatives are less intrusive on families than later interventions. Our social programs have shown that the kinds of responses that are necessary for a problem such as child abuse and neglect are far more intrusive in family life. Our culture respects and demands non-intrusive government, yet we wait for a child to be abused or a teen to become pregnant before we apply services and programs.

And prevention programs are effective. They require challenging methods of evaluation but they work. Evidence of preventing problems and the high costs associated with families living in poverty can be seen in the success we have experienced among the elderly population in Maine, and in the nation.

Twenty years ago the elderly were considered the most impoverished group of all citizens. Yet, today, their official poverty rate has dramatically decreased. These gains have been made as a result of income transfer and assistance programs such as Food Stamps, Social Security, subsidized housing, and Medicare. Advances in medical care and improved nutrition have also helped the elderly.

The same can be said for the prevention of infant mortality — Maine's rate is among the lowest in the country — because of the availability of prenatal care to low income women as well as the advances in early identification of problems and neonatal intensive care. Dental health problems in Maine are greatly reduced due to a simple preventive procedure — fluoride.

If we could prevent adolescent pregnancy, we could prevent unnecessary human pain and suffering for the teens, their parents and their children. We could prevent diminished futures.

If we prevented adolescent pregnancy we could save funds necessary to treat a high risk pregnancy, special needs infants and children as well as for the financial and social support for teen parents and their children. But without more effective prevention, we continue to need funds to counteract the adverse social, health and economic effects of teenage pregnancy and early, single parenthood.

We can no longer avoid the fact that children in Maine and throughout the country are falling into poverty at a spiraling rate and that there is something we can do about it. The rate for children under 6 living in poverty is 23% and increasing. By adjusting the figures to reflect AFDC, Food Stamps, housing, Medicaid and other income supports for families with children, their poverty rate declines only to 18%. The elderly rate declines from 14% to 4%. Federal expenditures are nearly ten times greater for the elderly than those for each child. And continuing cuts in children's programs and funding are common. While maintaining our commitment to our elderly citizens, we can also recognize the importance of improving the status of our children. Teen pregnancy is a matter of public policy, now, because these children can not wait.

We can start by working to prevent adolescent pregnancy while at the same time responding to the important needs of pregnant and parenting teens and their children.

The solutions are complex and it won't be easy. No one family or teenager can do it alone. Everyone has to help.

But what have we learned about adolescents by focusing on teenage pregnancy?

We have learned that teenagers have no real roles and responsibilities in our society. There are few jobs for them and fewer opportunities for them to experience success or to learn from their mistakes.

If they come from a family whose economic or personal problems are severe, they are likely never to have the opportunity for a secure future.

Many adults are not comfortable talking to teenagers, spending time with them or caring for them. It is often difficult for us to accept that they have a sexual identity. We don't understand them, their rebelliousness, or their assertiveness. They challenge us and we don't welcome it. And often, we expect the worst from them.

The teenager's role in society is at best confusing. They, at times, live in the worst of two worlds: the new morality following the sixties' youth rebellion and feminist movement, and the old morality which demands chastity, abstinence and adherence to strict family morals. Yet the youth growing up and going to war in the forties while listening to the Glen Miller band on leave were vastly different from the teens of today who fear nuclear destruction, family break up and listen to groups by the names of AC/DC, WHAM! and 38 Special.

We can not build healthy futures from confusion, ignorance and fear.

We cannot understand our youth unless we understand ourselves and our own sexuality. What makes teenagers feel, think and do the things they do are the same psychological drives, emotional needs and physical urges that adults have. Their confusion is our responsibility if we do not provide them with accurate information to make informed choices. We share in their mistakes if we do not give them clear messages about our expectations of them and help them learn to make healthy decisions. We alienate them further if we do not talk to them openly about sex, their feelings and their behavior, and listen to what they may have to say.

We believe it is up to the teen within the framework of family values to make moral, personal and sexual decisions. But our society needs to take aggressive action to assure that teens get clear messages from their families, that the teens who are sexually active use effective contraceptives, that the teens who get pregnant make healthy, responsible decisions and that the teens who become parents become the best possible parents they can be.

We can not afford NOT to respond to the teenage pregnancy problem — aggressively, dramatically, and committedly. It is to Maine's benefit to prevent problems, to save lives, and to build healthy, productive futures for children.

the work of the task force

When Governor Brennan asked the Task Force to study the problem of teenage pregnancy and parenting our first response was that it would be an overwhelming job. The task before us was both complex and controversial.

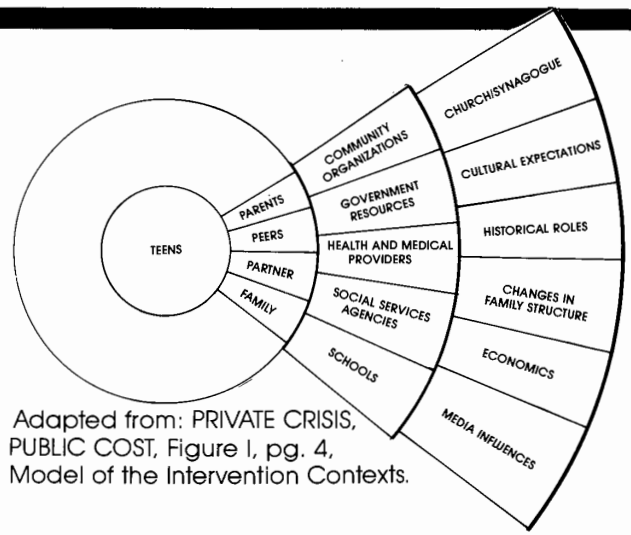
A 37 member group from diverse backgrounds — parents, teens, educators, physicians and nurses, clergy, municipal leaders, state bureaucrats, teen program directors, girl scout leaders, legislators, police, media specialists, and camp directors. We were asked to determine the most effective ways in which Maine parents, communities and government can assist teens in the prevention of adolescent pregnancy and parenting.

In carrying out our charge we divided our work into two parts: (1) strategies to delay pregnancy and parenting among Maine adolescents until they were capable of becoming responsible parents, and (2) strategies to provide services to pregnant and parenting teens to prevent subsequent pregnancies, promote the health and well-being of the parent and child and promote economic self-sufficiency.

task groups

When we looked at the issues involved with teenage pregnancy they formed three concentric circles around the teen.

We made each circle a task group: Circle One: The Internal Forces, Circle Two: The Systems' Response, and Circle Three: The External Forces. Members were assigned and asked to study the definition and root causes of the problem of adolescent pregnancy and parenting and effective approaches and innovative strategies to impact on the problem.



Adapted from: PRIVATE CRISIS, PUBLIC COST, Figure I, pg. 4, Model of the Intervention Contexts.

THE INTERNAL FORCES GROUP addressed the basic myths and biases that exist about teenage development. They discussed teenage sexuality as a normal aspect of human growth and development, and as an integral part of the whole personality. They focused on building self-esteem by meeting the emotional, physical, economic and educational needs of children well before adolescence and reinforcing these needs throughout their development. They addressed the difficulty teens have in getting accurate information from adults concerning sexuality and values; and the need for parents to communicate more helpfully and directly with teens. Important other issues were the need for sexually active teens to fully understand the risks and consequences of their choices, barriers to contraceptive use among teens and helping teens to obtain the services and support they need.

THE SYSTEMS GROUP began by determining an inventory of the ideal services needed to effectively impact on adolescent pregnancy and parenting. They looked at groups of people who should be targeted for services based on the "prevention triangle," a model for defining prevention by identifying populations, the occurrence or severity of their problems and the point at which they can be reached with services. From the development of the ideal system this group was able to focus on criteria for services, programs currently being provided, and the availability of services for: the community-at-large, parents and their children, adolescents at risk of pregnancy, sexually active teens, pregnant adolescents and teen parents and their children.

THE EXTERNAL FORCES GROUP focused on the changes occurring in the structure of families and needs of family members; the impact of the economy on families; the role of communities in helping teens develop a strong sense of responsibility; and the lack of opportunities for meaningful decision-making and responsible work for teens. They addressed the continued view of women as sex objects; the influence of advertising, television, music and other mass communication mediums, and government's role in setting policy and supporting families.

public forums

Midway through the Task Group work we took our issues directly to the public for their response. Six public forums were held in communities throughout the State; two additional forums were developed specifically for youth populations, one at Lisbon High School and the other during a conference on "Poverty in Maine" at Bowdoin College in Brunswick. In order to focus the public's response we developed several questions for their consideration:

First, Why do you think our teen birth rate is higher than other states?

Second, What services and organizations are available to teens in your town? Are there any innovative programs designed to respond to teen pregnancy issues?

Third, Do teens have jobs and community responsibilities in your town? How would you suggest they take a more active role?

Fourth, How can parents become better educators for their children on the subject of teen sexuality and pregnancy? What should the community do for those teens whose families do not assume that educational responsibility?

And, lastly, What role should the family, churches, teens, agencies, schools, and others take in working toward the prevention of adolescent pregnancy?

More than five hundred people attended the forums, some of whom provided oral testimony; others wrote their comments to us; and still others came to observe and listen. An additional 300 young people were involved in the Lisbon forum. The forums offered the opportunity for the public and the Task Force to engage in a dialogue on the issues. They provided a particularly exciting public exchange among adults and teens about sex and sexuality; for many this was a "first."

diverse views and minority votes

It was important to the Task Force members to work toward the development of consensus of opinion about their recommendations. This was difficult, at times, given the diversity of the group and the nature of the issue. We found that it was impossible to consider a response to teenage sexual behavior without confronting our own values and reactions to sex and sexuality issues. Becoming comfortable with the topic was essential. In fact, it is the discomfort with sexual issues that we believe has contributed to the problem of adolescent pregnancy by alienating teenagers from adult guidance and support. For us to overcome the barriers of communication and different values was critical. Our goal was to act as a model for agreement and consensus for Maine communities.

We created a process by which members could submit a "minority statement" to explain their disagreement with a specific recommendation. (formal vote was taken, then the opposition prepared a statement. One person in opposition to a recommendation could write a minority statement.) Specific recommendations on which members could not agree are noted in the text. For a description of the debate and differences, readers are referred to the section following the recommendations entitled: Explanation of Minority Votes. The Task Force believes that understanding these differences may help citizens in their own communities to work toward the common goal of preventing teen pregnancy and parenting in Maine.

who can help?

After nearly one year of deliberations, the Task Force offers recommendations, for public consideration, to effectively impact on the many forces which influence teen pregnancy and on the systems designed to respond to the problem. But the Task Force report goes one step further. We suggest not only what can be done, but how it can be done and by whom.

We believe that teen pregnancy is everybody's problem, that the sexuality and sexual behavior of our teens are historical and cultural issues and that their pregnancies and their children are our shared responsibilities as parents, and members of Maine communities. We identify ten groups of people for which we assign specific roles and dozens of strategies:

We recognize that TEENS themselves bear the ultimate responsibility for a series of decisions which may result in pregnancy or parenting: whether to postpone sexual activity, to begin sexual activity, to contracept, to become pregnant or to become a parent. However, teens do not live in a vacuum. They are influenced by many external and internal forces.

Many teenagers are living with their FAMILIES when they initiate sexual activity and most teens are still living at home when they become pregnant. Whether teens remain with their families or not, their families play a significant and powerful role in both the teens' decision making and their behavior. Their families' views affect decisions, while family resources can assist when pregnancies occur.

COMMUNITIES have a broad and important role as well. It is within the community that families meet their basic survival needs, find support for their emotional and spiritual selves and interact with other families. Communities are made up of people who themselves take on roles that are integral to the success of family members and, at times, the family unit itself.

Beyond the community as neighbor, family, and friends, there are systems in the community that impact on teens. They have distinct roles and particular responses: THE EDUCATIONAL SYSTEM, CLERGY AND RELIGIOUS ORGANIZATIONS, THE MEDIA, THE HEALTH AND MEDICAL COMMUNITY, THE SOCIAL SERVICES' SYSTEM, BUSINESS AND EMPLOYERS AND STATE AND FEDERAL GOVERNMENT.

The recommendations are designed for you, as the reader, to refer to the section that most involves your interests and your role with teens, or in your community. There is duplication of recommendations when the Task Force believed that dual roles and responsibilities existed. In their entirety, however, our recommendations bring all citizens together in a framework that can move us toward our common goal of delaying teenage pregnancy and parenting in Maine.

the problem

what the numbers tell us

Teenage pregnancy is a serious health, social and economic problem in Maine and in the nation. Each year over a million American teenagers will become pregnant, four out of five of them unmarried, and 30,000 under age 15. Although adolescent fertility rates have been declining in the United States, as they have in much of Europe, teenage fertility is still considerably higher in the United States than in the great majority of other developed countries. In fact, the abortion rate alone in the United States is about as high as, or higher than, the overall teenage pregnancy rate in many other countries. (Jones, et al., 1985)

Maine's adolescent fertility rate (or pregnancy rate) is 70 per 1000 women age 15-19, as compared to the U.S. rate of 96 per 1000. Though Maine's teen pregnancy rate is lower than the national rate, comparing states makes it clear that Maine has a serious problem: Maine ranks sixth highest in the country for births to single white mothers, age 15-19. Graphic 1

One in 14 of Maine teenagers become pregnant each year. Of the more than 3000 pregnancies every year, over one-third end with an induced abortion (1000), a very small percentage (3%) end in spontaneous abortion or fetal death, and the remaining 2000 pregnant teenagers (two-thirds) carry the pregnancy to term. Graphic 2

One in 21 of Maine teenagers become mothers. The majority of teen females who give birth become single mothers, more than 1100. Very few mothers choose adoption. Based on estimates from the U.S. Census which reports that only 8% of babies born to unmarried women under 25 are released for adoption, there are at most 80 teen mothers in Maine who choose adoption each year. The remaining teen mothers, less than 900, were married or became married at the time of birth. Often these marriages do not last: one out of five result in divorce during the first year; one out of three within two years.

The problem of adolescent pregnancy is not new. Although the adolescent birth rate has declined steadily since 1960, as has the total birth rate for all Maine women, there remain two areas of concern for Maine. Graphic 3 The birthrate for Maine teens age 16 and younger has NOT decreased, and a steadily increasing number of young women are becoming single mothers. Graphic 4, 5 & 6 In fact, 1985 preliminary data reveals that on a percentage basis, the rate of birth to single teens is rising about three times faster than the rate of births to all teens is dropping. While some teens are able to meet the challenge of single parenting with few problems, for most being a single teenage mother becomes an emotional, social and economic hardship. This is particularly true for teenagers who have second or third or even fourth children while still in their teens, a group which accounts for about 18% of teenagers giving birth each year. Graphic 10 & 7

Most adolescent pregnancies are considered by the teen mothers to be either "mistimed" or "unwanted" according to 1983 national fertility data. While mothers in their twenties and thirties reported their infant's births to be planned in about 60% of incidences, mothers in their teens reported births to be planned only about 20% of the time.

The younger the teenage mother, the more likely that the baby's father will be listed as "unknown" on the birth certificate. Graphic 8 This is true for 64% of Maine teen mothers under 16. Of the percentage reported, more than 50% of the fathers were 19 and older. Among the mothers, age 16 and 17, 50% of the fathers were known; of that figure close to 80% were 19 and older. Graphic 9 This supports a consistent pattern of fathers being older than mothers with an age difference of 5-10 years being common. Very few of these men provide financial support for their children. A review of nearly 900 single teenage mothers on welfare in Maine found that only 15% had legal child support obligations from the fathers. Child support from a father who is under 19 is rarely provided.

Comparisons among Maine's counties are interesting. Not surprisingly, Maine's poorest county (Washington) also has the highest rate of teenage births. The least poor

counties (Cumberland and York) have the lowest teenage birth rate. To understand the extent of the problem in any county it is useful to compare the rankings of teenage birth rate, abortion rate and pregnancy rate. For example, Cumberland County has the lowest teenage birth rate in Maine. One significant factor is that it also has the highest rate for induced abortions. Better access to contraception may also contribute to the lower birth rate. Washington County, however, has the highest rate for both teenage births and pregnancies with the third highest rate for abortions. A teen in Washington County is more than twice as likely to become a teen mother than a teen in Cumberland County. Graphic 11,12,17 & 14

Comparisons in other states reveal that while childbearing by all unmarried women is at an all-time high throughout the country, the rate for unwed teenage mothers, nationwide, went down in 1984 — for the first time in six years. Childbearing by all unmarried women rose between 1983 and 1984 to the HIGHEST levels observed since 1940, when national statistics were first collected. The growth in the population of unmarried women has outpaced that of all women because of the widespread tendency to delay marriage to increasingly older ages, as well as the increasing number of divorces. While many women have been delaying marriage, some seem to have decided to go ahead with having children, before they reach the age where childbearing may become physically risky or impossible. In addition, experts say, social pressure on single women to wed after becoming pregnant has declined in recent years as the stigma of having an out-of-wedlock child has lessened. (National Center for Health Statistics, 1986)

Although the reductions in the rates were relatively small, the rates of teenagers 15-19 years old dropped to the LOWEST levels observed in the United States since 1940. Between 1983 and 1984 the birthrate for even younger unwed girls (age 15 to 17) declined from 22.1 to 21.9 births per 1,000 girls; the first decline since 1978. Unwed 18 and 19 year olds had an increase. In Maine, births to single teens have consistently increased for every age group. The number of births from 1984 to 1985 among all teens (married and single) decreased by 3% while births to single teens increased by 8%.

Comparisons to other countries show those countries with lower teenage birthrates are generally more open about sex, provide more learning about contraceptives in schools, and make free or low-cost contraceptives available to teenagers. The countries studied in the Alan Guttmacher Institute research were chosen because they were culturally and economically similar to the U.S., and because it is believed that sexual activity among young people in these countries is similar. Graphic 13 Of particular significance is that five of the countries studied — France, England/Wales, Canada, Sweden and the Netherlands — had a more equitable distribution of income for families at the bottom of the economic ladder.

"Poverty to the degree that it exists in the United States is essentially unknown in Europe." (Jones, et al, 1985) In addition, all the countries studied provide more extensive benefits to poor mothers that usually include medical care, food supplements, housing and family allowances, than the United States. In the United States one out of every five children is poor — more than 13 million American children. The younger the child the higher the poverty rate: Twenty-four percent in 1984 for children younger than six. Children living in female-headed, single-parent families experience even greater poverty, close to 54 percent. (CDF, 1986) Another study looked at median income in each of six western countries. It showed that the United States has a greater percentage of children in families whose income is less than one-half of the country's median income: 24.4% compared to Israel (18.6%), Canada (16.8%), The United Kingdom (10.4%), Germany (6.3%), Norway (5.6%), and Sweden (5.2%). (Kahn, 1986)

When teen parenthood, single-parent status and low-income combine, an endless spawning ground of serious health and social problems is created. (Petit, 1986)

what the numbers tell us about the costs

health costs:

The younger the teenager, the more likely her pregnancy will end in abortion. Pregnancies end in induced abortions about four times more often for teens under age 15 than for women over age 19. Of the 3000 teen pregnancies each year in Maine, approximately 1000 end in induced abortion. (Repeat abortions appear to account for a small percentage of cases. Of the total induced abortions among Maine teens in 1985, a reported 12% of the women had a previous induced abortion, and 9.6% had a previous live birth. These repeat pregnancies might be the result of contraceptive failure, since about 11% of women who contracept become pregnant.) Graphic 14

Pregnant teenagers are less likely to get prenatal care and good nutrition during pregnancy, increasing the risk of health problems for themselves and their babies. During 1984 in Maine, 88% of the first time mothers over age 19 received prenatal health care in the first three months (trimester) of pregnancy, compared to 70% of those age 17-19, and only 56% of those age 16 or younger. Graphic 15

Pregnant teenagers have a higher incidence of complications to pregnancy including eclampsia/preclampsia, anemia, urinary tract infections, and premature labor and delivery. The percentage of complications among teenage pregnancies in Maine was higher for those age 15 and under. An additional risk factor found was that mothers age 19 and younger were nearly twice as likely to smoke cigarettes as those over 20. A number of recent studies have shown that cigarette smoking increases the risk of spontaneous abortion and low birthweight babies.

Infants born to teenagers are more likely to be of low birthweight (less than 2550 grams) or very low birthweight (less than 1500 grams). Over the past 15 years in Maine, teenage mothers have been about 30% more likely to have given birth to a baby of low birthweight, and 40% more likely to have given birth to a baby of very low birthweight than was the average mother. These babies have a higher risk of cerebral palsy, epilepsy, mental retardation and other problems, as well as a higher infant mortality rate. Mothers less than 16 years old have greater risk of having low birthweight and very low birthweight babies. Mothers age 17 and older had newborns with characteristics similar to those of adult women. The pregnancy outcomes were less favorable for those who were not married at the time of delivery, whether or not they were married at the time of conception. This is probably due to lack of early prenatal care. (Makinson, 1985) Graphic 16

Infants born to teenage mothers have a lower APGAR score at birth, a measure of the infant's general condition which includes the infant's heart rate, respiratory effort, muscle tone, irritability and color. In 1984 APGAR scores for babies of teen mothers in Maine were lower than for babies of mothers over age 19, a lower score more likely with youngest mothers.

Earlier studies have shown that the younger the mother, the greater the risk of maternal complications, low birthweight babies and infant mortality. Students since 1970 suggest that these increased risks, especially to those over age 15, are associated more with poor prenatal care among teens than with factors specifically related to age.

educational costs:

Adolescent pregnancy is the major cause for teenage women dropping out of school. Nationally, no more than 50% of school-age parents graduate from high school. Of mothers under the age of 14, four in ten never even complete the eighth grade, nine in ten never finish high school. These young people lack the skills and resources to enter the job market competitively, though with a child or children to support they are more in need of employment.

Mothers who give birth before the age of 18 are only half as likely to graduate from high school as those who have children later.

Teenage fathers are 40% less likely to graduate from high school than those who have children later.

Teenage mothers who complete high school education are less likely to suffer the social and economic disadvantages that often follow early childbearing.

economic, social and psychological costs:

Teenage mothers are more likely to be dependent on welfare, especially those who do not complete a high school education. Over half of the women currently receiving Aid to Families with Dependent Children (AFDC) were teenagers when they had their first child. This translates into $4.5 billion invested nationally on these benefits.

In Maine, this translates to approximately $50 million per year.

One measure of the economic consequences of teen pregnancy and parenting is to look at Maine women currently enrolled in the AFDC (Aid to Families with Dependent Children) Program.

A "snapshot" of the AFDC caseload taken January, 1986 showed both the cost of services to the current heads of households who were teenage parents as well as the women among the total population of AFDC clients who had given birth to their first child in their teens.

Of the more than 18,000 female heads of households in Maine enrolled in the AFDC program in January, 1986, 48% or 8730 had their first child as a teenager. If we look at the child population enrolled in the program there were 17,000 or 52% of the total receiving AFDC whose mothers had been teen mothers. These women and children receive AFDC and food stamp benefits totaling $4.2 million for the month of January. At this rate of expenditure these benefits alone would cost $50 million annually.

Of that figure, there are 977 heads of households who are still in their teens, the majority of whom are older teens. Their total AFDC and Food Stamps cost $380,000 in the month of January. Annualized that figure for teen parents alone, is $4.6 million per year.

family support costs:

Health, medical and social service costs of adolescent pregnancy in Maine are at least $60 million per year.

Maine has no current methodology to determine the full impact of the cost of teen pregnancy and parenting throughout the state. Government bears the burden of teen pregnancy in terms of welfare and family support expenditures. Because teen pregnancy can be linked to so many other problems in society, those costs must be figured in.

A State of Illinois study of the costs of teengage pregnancy and parenting looked at the current caseload of teen parents on AFDC and Medicaid including Birth and Newborn Care, day care costs for children of teen mothers who were working, regular medical care and support for non-welfare children, and prevention costs. If we extrapolate their costs to Maine's population, the costs would exceed $60 million a year on the current population of pregnant and parenting teens. All of the substantial schooling costs and most of the social costs are excluded, therefore the $60 million is a conservative estimate. In addition, there is no way to measure the loss of human potential from an early and unintended pregnancy.

Adolescent mothers encounter negative social pressure and experience alienation from their family members and peers. Early parenthood interferes with adolescent development by creating a conflict between the adolescent's need for independence and her continued dependency on the adult world.

Teenage parents who marry have a high rate of divorce: one in five teen marriages will break up within the first year; one in three within two years. According to U.S. Census data, teens are twice as likely to dissolve their marriages as couples who marry in their twenties.

Child abuse and neglect are higher among families which began with a teenage pregnancy, especially if other factors are present such as poverty, teen parents having been abused as children, unrelieved child care, low level of education or substance abuse. Children of teenage mothers are more likely to suffer physical neglect such as inadequate nutrition and health care than to suffer abuse. However, the quality of mothering depends more on the mother's education and family supports than on her age alone.

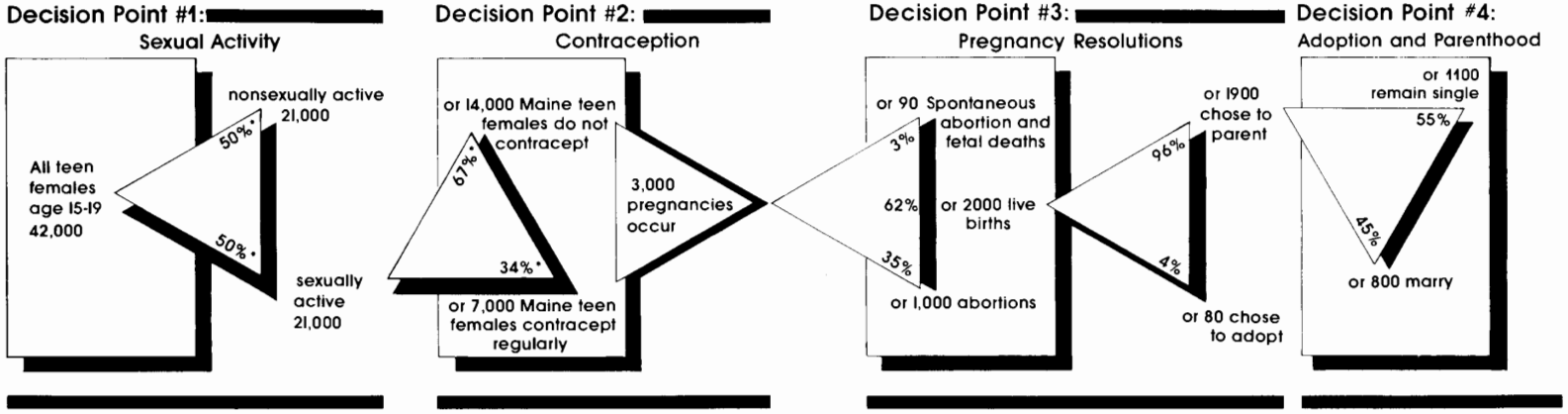
In Maine during 1984 there were 246 families headed by a teenage parent receiving Child Protective Services from the Department of Human Services, representing 3% of the 8200 case total. Of cases involving teen parents, 199 or 81% were clients of AFDC and/or Food Stamps as well, supporting the idea that financial difficulties increases the likelihood of neglect and abuse. More children of teen parents were found to be victims of neglect than of abuse. Of 111 substantiated cases, 69 involved neglect, 33 physical abuse, and 9 sexual abuse. The link between child abuse and AFDC status is apparent in that the majority of child abuse cases are from AFDC families. Given the correlation between teen parenting and AFDC, the increased risks of child abuse and neglect can not be overlooked.

what the numbers tell us about the teens

decisions leading to adolescent parenthood

The Task Force worked, through research and the participation of teens, teen parents, and professionals, to understand the individuals behind the numbers used to describe the problems of adolescent pregnancy and parenting. They found it helpful to look at four different steps in the process leading to adolescent parenthood. Each step involves a decision point, or the lack of a decision, as outlined below with the percentage distribution of women age 15-19 at each of these points.

DECISIONS LEADING TO ADOLESCENT PARENTHOOD



*These percentages are based on national data from a 1980 study by Zelnik and Kantner. All other data is based on approximated figures from 1985 Maine data.

A summary of research findings offers some important conclusions about the individuals at each step in the decision-making process.

decision point 1. becoming sexually active

There is much concern and debate about the extent to which sexual activity (defined as ever sexually active) has increased among teenagers. Data on sexual activity among Maine teens is not available. 1979 study of metropolitan teenagers found that 69% of females had had intercourse by age 19 and 78% of males had had intercourse by age 19. (Zelnik and Kantner, 1980) This represents a dramatic increase over the past fifteen years. The proportion of U.S. females age 15-19 who have had premarital sexual intercourse increased from 30% in 1971 to 50% in 1979. (Zelnik & Kantner, 1980) The average age of first intercourse for U.S. females is 16.2; for males 15.7.

Given its mandate, the work of the Task Force focused on those teens who are sexually active, since they are the ones at risk of pregnancy. (It should be noted that a significant number of teens indicate that they became pregnant after only one sexual experience.) Task Force members recognize that at least half of Maine teenagers probably are not sexually active, and they need to be affirmed for making this choice in the midst of a cultural

climate that makes it seem as if "everyone is doing it." Much work of the Task Force focused on ways to encourage more teens to delay sexual activity. Nevertheless, the increase in sexual activity is significant, reflecting a societal shift towards more acceptance of sexual activity before marriage. Of white females who married in 1960-64, only 47% had had premarital intercourse, while of those marrying in 1975-79 that figure had increased to 78%. (National Center for Health Statistics 1985) A trend towards later marriage contributes to this figure.

The Task Force heard from adults who believe that sexual activity before marriage is morally wrong. Some maintained that the answer to the problem of adolescent pregnancy was abstinence. Other individuals supported the need for adolescents to develop a healthy and responsible understanding of their sexuality, which might or might not include sexual intercourse in later adolescence. Again, this reflects a societal change in attitudes as reflected by a 1985 Gallup Poll finding that 58% of U.S. adults accept premarital sex as compared to 24% in 1969. The majority of the Task Force felt that they should not make individual moral decisions about when it might be appropriate or inappropriate for a teenager to have sexual intercourse. Such decisions were subject to individual values, and were more suitably guided by parents.

But the Task Force felt strongly that it was important to protect both the individual teenager and society by assuring that its recommendations did not promote an increase in early adolescent sexual activity. In fact, everyone has much to gain by reducing early sexual activity.

The Task Force sought to understand who the teenagers are who become sexually active in an effort to develop effective prevention strategies. While teenagers from all backgrounds may well be at risk, survey of the research on teen pregnancy found that sexually active teens are more likely than their non-sexually active peers to have the following characteristics:

low socioeconomic status
low educational and occupational aspirations
single-parent families, or large families
sister or mother who was a teenage parent
less involved parents than teens who are not sexually active
less religious than teens who are not sexually active
value independence more and achievement less
engage in unconventional behavior such as alcohol or drug abuse
value the views of peers more than those of parents
perceive that their peers are sexually active whether they are or not
have not had sexuality education
hold more stereotyped views of women and men
are more susceptible to pressure from their boyfriends
less able to say no to sexual intercourse or otherwise influence their relationships with their boyfriends
feel less sense of influence over their own decisions and future

(Flick, Public Health Reports, 1986)

Some teenagers who become sexually active appear to do so to meet needs in their lives for love, affection, acceptance and in many cases to please their boyfriends. Others who are disadvantaged and have low self-esteem have a particularly difficult time saying no to pressure they receive from their boyfriends to have sex. And many teenage females do not actually DECIDE to have intercourse. They may feel that it is not right to have sex. But if their feelings are so strong in the moment of passion that "it just happens," they feel that sexual intercourse may be acceptable. The majority (60%) of teenage women were going steady or engaged to their first sexual partner, but they felt they had less influence over their dating relationships than non-sexually active teen females. (Flick, 1986)

The Task Force also heard from parents who believe that responsible youth are capable of having healthy sexual relationships. They are usually described as older adolescents often involved in long term loving relationships where contraception is used.

decision point 2. contraceptive use

Once a teenager becomes sexually active she or he enters a new category of risk for becoming a parent. While there has been an increase in use of contraceptives among teens, many still engage in unprotected intercourse or use contraceptives sporadically. Among premaritally sexual active females age 15-19:

34% reported always using contraceptives
27% reported never using contraceptives
39% reported inconsistent use

There has been much speculation as to why teens do not use contraception, even though in some cases they have the knowledge about reproductive physiology and about methods of birth control. In some cases they may want, either consciously or unconsciously, to become pregnant. Teenagers who have had a sex education course are more likely to use contraception once they begin sexual activity than teens who have not had such courses. They understand their bodies, contraceptive methods and the consequences of pregnancy. (See Section: Educating Our Children About Sexuality) But education, when it is provided, is not enough to motivate teens to protect themselves from an unplanned pregnancy. Part of the explanation lies in the fact that younger adolescents, especially those under 16, are not likely to have developed the cognitive skills required to make a decision about protecting themselves from a future consequence. Their thinking is still located in the immediate. In fact, the younger a teen is when she begins to have intercourse, the less likely she will be to use contraceptives. Only 31% of sexually active females under age 15 used any methods, whereas 62% of those 18 or older reported using contraceptives at first intercourse.

Among the reasons teenagers themselves cite for not contracepting when they begin sexual intercourse are:

lack of preplanning for intercourse
unavailability of contraceptives
lack of knowledge of contraception
thought that pregnancy is impossible

Other reasons include refusal to use contraception and desire for pregnancy.

It is interesting that for both teenage females and males a major reason for not using contraceptives is unavailability. The majority of teenagers, during their first year of intercourse, use non-prescription methods of contraception, either consistently or sporadically, and these are readily available at drug stores. Factors such as fear and embarrassment about being seen at the store purchasing contraceptives often play a large role in teens' perception that methods are unavailable. Rural isolation may make it especially difficult for teens to either delay sexual activity or obtain contraceptives. For those teenagers who have used contraceptives, use of the pill and IUD increased during the seventies, but from 1976-79 use of these methods declined about 41%, while withdrawal and rhythm (or natural family planning) increased by 86%. Clearly, teenagers are trying to prevent pregnancy, but they are using the least effective methods in doing so, which may be a major factor in rising teen pregnancy. (Zelnik & Kantner, 1980; Zelnik & Shah, 1983)

In Maine, family planning clinics saw over 11,000 patients under age 20 in the past year, or about 25% of all teen females in the state. Others may use over-the-counter contraceptives, withdrawal or rhythm, or consult a private physician for contraception. Generally there is about a one year interval between a teenage female's first intercourse and the time she gets a prescription method of contraception (pill, IUD, or diaphragm). (Zelnik, Koenig, & Kim, 1984) Many go to a family planning clinic or private physician for the first time because they suspect they are pregnant. This time interval between the beginning of intercourse and the use of effective contraception is a problem because a substantial percentage of unmarried adolescents get pregnant within a few months of beginning sexual activity. Some pregnancies occur among women using contraception: about 11% will become pregnant due to contraceptive failure, or 6% for those using the more effective medical methods.

The Task Force discussed at length the appropriateness of making contraceptives more accessible to sexually active teenagers. Their major concern was to meet the needs of those who had decided to become sexually active, while at the same time supporting those who say no to sex. Some Task Force members were opposed on religious or moral grounds to the use of any contraception other than "natural family planning" (rhythm), which entails a woman's monitoring of her fertility and abstaining from intercourse at times of the month when the risk of pregnancy is highest. Even those who held this view agreed that this method is not effective with teenagers because it requires preplanning and self-

control for which most teenagers are not prepared. Some Task Force members opposed promoting the use of contraceptives among unmarried teenagers, fearing that such action would condone and encourage premarital sexual activity. Others, particularly the teenagers attending the public forums, emphasized that some teenagers are going to be sexually active whether their parents approve of it or not and that they need assistance in preventing pregnancy. Given the length of time between the first intercourse and a prescription method of contraception, it can be concluded that teens have sexual intercourse whether contraceptives are available or not. The majority of the Task Force came to feel that improving the availability of contraception was an essential aspect of preventing teen pregnancy, but far from the whole solution.

A major issue related to teenagers' use of contraception is parental consent. In Maine, minors can receive medical services without their parent's consent for family planning, sexually transmitted diseases, alcohol and drug abuse treatment, and mental health services related to suicide prevention. While this right assists the teen who is unable to discuss these matters with his or her parents, it has led certain members of the public to feel that it undermines parental authority and responsibilities. (Ooms, 1984) Health care professionals are caught in the middle between respecting the needs of teenagers for confidentiality and health services, and respecting the rights of the parents to be involved in such decisions. Health providers do make an effort to encourage teenagers to discuss these matters with their parents, often helping them to see that their parents may be more understanding than the teenager expects. However, in some families, particularly those with problems of physical or sexual abuse, or of substance abuse, such communication is not only impossible; it could be harmful to the adolescent's health and safety.

As with decisions about sexual activity, the Task Force felt that the use of contraception by teenagers was a decision to be made according to individual values, guided by parents. The majority of the Task Force believed it was important to improve the availability and accessibility to contraceptive services for teenagers who are sexually active, while at the same time providing education and one-to-one counseling to help teenagers say no to sex, and to affirm those teenagers who value abstaining from sex outside of marriage.

In reviewing the research, the Task Force found that teenagers who use contraception are likely to have the following characteristics:

- high socioeconomic status
- two-parent families, or small families
- better relationship and greater involvement with mother
- belief in the risk of pregnancy, or have experienced a pregnancy
- sexuality education including information about contraception
- older age at first intercourse
- in school or working
- higher academic achievement and aspirations
- higher self-concept and sense of control over their lives
- acceptance of sexuality and positive attitudes toward sex
- non-traditional views on female roles
- sense of power and influence with their boyfriend
- going steady or living with their boyfriend
- better communication, including ability to discuss birth control with boyfriend

(Flick, 1986)

What emerges from the research is a picture of the teenager who has more hopeful prospects for the future being one who protects herself from an early, unplanned pregnancy. Again, those teenagers from poverty status having little sense of control over their lives follow the path that increases their chance of early pregnancy.

decision point 3. pregnancy resolution

One-third of the pregnancies among teenage females in Maine, as in the United States, result in an induced abortion. Regardless of one's moral convictions about whether abortion is right or wrong it is important to acknowledge that it is a legal medical procedure teenagers can choose when they become pregnant. The majority of teens express attitudes towards abortion that are more conservative than those of adults. (Zelnik & Kantner, 1975) Most view abortion as acceptable only under circumstances such as rape or fetal defect. Data

Are Welfare Benefits an Incentive? The suggestion is often made that welfare benefits such as AFDC serve as an incentive for teenagers to get pregnant and become single parents. There is no research evidence that this is the case. The level of welfare benefits in a state is not related to the rate of teen pregnancy. If these benefits were an incentive, one would expect states with the highest benefits to also have the highest pregnancy and parenting rates. It does appear to have a substantial effect on the living arrangements of young single mothers. Unmarried mothers are considerably more likely to move out of their parents' households in order to qualify for benefits. And young married mothers are somewhat more likely to become divorced or separated in states where benefit levels are high. States with lower wage rates and higher levels of unemployment had more births to unmarried women and more women living as single heads-of-households. The major national study conducted by Harvard researchers found that "AFDC really is not the primary cause of or influence on key family structure changes that are receiving attention in the media. A dramatic cut in welfare would change the lives of poor women. It would reduce the incomes of single mothers. It would influence the location where many young single mothers live. And it might even reduce the number of single mothers slightly. But, ultimately, it would do little to slow the growth of single-parent families. Welfare simply does not appear to be the underlying cause of the dramatic changes in family structure of the past few decades." (Ellwood & Bane, 1985)

teenage parenthood: important questions and concerns

What do we know about the age of the father? Who are the teen fathers? What is the relationship between teen females and older fathers? Is there a link between the teens who are substance abusers and teens who become parents? What is the link with sexual abuse? What becomes of the teens who marry? What is it like being a single parent?

To understand which teens are more likely to be at risk of pregnancy and parenting and the consequences they face, we looked at these important factors:

the age of the father,
the link to substance abuse,
the link to sexual abuse,
teens who marry,
and single teen parents.

teenage mother/teenage father

The greatest difficulty in examining the age relationship between the teen mother and her partner is that paternity is not established in the majority of cases. (Generally, the father is named on the birth certificate. Later, through proper medical testing, the father's identity can be established after the birth.)

Among the youngest teens, 15 and under, the father is rarely named (50% of those named are 19 and older). By age 16 and 17, paternity is established at birth in 50% of the cases — 75% of the fathers are 19 and older. The older the teen the more likely paternity is established and the more likely the teen mother will be married.

We do not know how many of the unnamed fathers are teens.

A portrait of the teen father in Maine is not easily sketched. Anecdotal reports suggest that the adolescent father has low self-esteem and poor school performance and attitude, that he is self-centered and irresponsible and takes advantage of young women sexually, without thinking of the consequences of his behavior.

But much research indicates otherwise — that adolescent fathers are proud of their children and involved in their support, that many young men go through the same emotional struggles and confusion that young mothers do. In fact, teenage fathers often want babies as much as teenage mothers do, for many of the same reasons: child may be the first thing in their young lives that seems mostly theirs; for those doing badly in

school, caring for a baby may be their first tangible accomplishment; for those reared in troubled homes, a baby may be the first human from whom they can receive love. (Robinson & Barrett, 1985).

But not all adolescent fathers are permitted or encouraged to offer support. Young fathers are often left in the dark when decisions are made abut their babies, primarily by the mother and her parents. Teenage fathers are often not told when the baby is born. Likewise if paternity is never established, he may never know if the baby has been adopted or turned over to foster care.

In fact, if society seeks these young men out at all, it is usually with punitive and judgmental intent and for child support. Whatever rights they may have with regard to their child are generally ignored — except their financial responsibility or release for adoption. (Johnson & Staples, 1979) In addition, prospective teenage fathers usually have few friends with whom they can discuss their troubles, fears, and feelings. (Johnson, 1978)

By compiling information from numerous studies, a profile of the teen father emerges. One study (Pannor, Massarik, and Evans, 1971) revealed that most unwed fathers will participate in counseling and are willing to accept responsibility regarding their girlfriend's pregnancy. However, if the social agency does not persist in attempts to reach these young men, they will probably not come forward on their own. Most fathers reported that they felt left out and doubted that the agency was genuinely interested in being helpful.

A Time magazine article (12/9/85) entitled "The Missing Father Myth" described the typical teenage father as finding himself "treated as an outsider, receiving none of the solicitous attention that occasionally attends the mother and child." One counselor: "The paradox felt by teen fathers is that while they want the young lady to receive services, they are ambivalent because they can't provide for them the way they should. It defeats their masculinity."

For the male there are feelings of guilt and responsibility. Some males may feel this responsibility and decide to marry. Yet nearly 50% of adolescent (under 20) marriages end in divorce within 5 years.

It is not known whether vigorous enforcement of child-support payment laws will deter irresponsible attitudes and behaviors of unmarried fathers, or whether job-training affects the initiation of sex, frequency of sex, or the motivation to avoid pregnancy. But job-training does have a positive effect on teenage fathers after the birth of their children.

A study by the Ford Foundation revealed that many young fathers are not only willing but eager to help their partner and offspring. A two-year project was established which offered vocational services, counseling, and prenatal and parenting classes to nearly 400 teenage fathers and prospective fathers in eight U.S. cities. At the end of the program, 82% of the fathers reported having daily contact with their offspring; 74% said they contributed to the child's financial support; almost 90% maintained a relationship with the mother. At the end of the program, 61% of the previously unemployed young men had found jobs. Perhaps more important, 46% of those who had dropped out of school had resumed their education.

In another study of unmarried parent couples (Gershenson, 1981) the fathers' involvement was directly related to the mother's plan for the future of their relationship. Among those couples who were married or planning to live together in the near future, boyfriends were more likely to actively participate in child care. In that same study, there was either full agreement or no discussion over the issues of day-care arrangements and feeding the child. Discipline was the area where the mother and boyfriend were most likely to disagree, although there was no trend in the nature of the differences. None of the boyfriends were heavily involved in the financial support of their girlfriends and their children, although economic cooperation was beginning among the engaged couples.

Children receiving their father's name are more likely to have contact with their father and to receive economic assistance from him. A study of children of parents who did not marry found that they were frequently named after the father, describing the practice as a deliberate attempt on the part of the parents to strengthen the father-child bond. Approximately 50% of the children received their father's first name, middle name, or both; 43% of the boys, 46% of the girls were given their father's last name, even when the parents remained unmarried.

teenage mother/older father

While much of the Task Force's work was devoted to the teenage mother and her baby, there was concern about the age difference between these women and the fathers of their babies. Of 1264 births to teenage mothers in 1984 for which the ages of both mother and father were known, the average age of the father was 26 years.

The fact that 30% of the fathers of babies born to teenagers were 3-4 years older than the mothers, 25% were 5-9 years older, and 5% were 10 or more years older was alarming, particularly considering how few of these fathers provided any financial support for their babies. While little data or research is available on the fathers, the Task Force spoke with counselors who work with both the teenage mothers, and in some cases the fathers of their babies to attempt to understand the dynamics involved with the difference in ages. (Although these interviews are in no way scientifically accurate, they provide us with the anecdotal profile from the experience of the workers.)

The majority of the young women involved with older men were from single parent homes. Many seemed to be looking for a rescuer, for someone to take care of them. Where there was an older male at home, a stepfather or mother's boyfriend, the relationship was described as adversarial. They're looking for someone to fill the missing father role. With the males it appeared to be self-esteem problems — they needed someone to look up to them. These men may have felt insecure with women their own age, more today when women are more assertive; they can have power over the younger girl. The men were often family acquaintances, such as friends of the mother or of an older brother. The relationships were in many cases incestuous, or the girl had previously been a victim of incest or sexual abuse.

The issues of status and self-esteem came up repeatedly — that an older man with money, a job, and a car was a status symbol in the eyes of many teenage girls. And the lack of self-esteem in both the teenage girl and her older boyfriend often drew them together. The girls, in particular, may have seen the older man and the pregnancy as ways to get out of an abusive home situation. For these young women, learning to say no to sexual intimacy which is exploitive and harmful is especially difficult because they may not believe they deserve a better relationship, or they may see sexual activity as a way to recover some desperately needed self-esteem.

links with sexual abuse

The link between previous sexual abuse and teenage parenthood is important. A child that has been sexually abused will start to engage in other types of sexual activity at an earlier age, will tend to engage in more promiscuous, self-destructive and problematic kinds of sexual behavior, and will be more like to be sexually victimized again.

All of these factors place them at higher risk for teen pregnancy. The reason for the connection is that children who are sexually abused are brought up in an environment where they trade sexual contacts for getting their emotional and developmental needs met. They also learn that they are powerless to stop sexual advances, which is why they also tend to get victimized later in their lives. In addition, they feel a great deal of stigma. Since they feel themselves to be sexually tarnished, they feel that there is no virginity or purity for them to protect. (Finkelhor, 1986)

Among female victims of sexual abuse, there is often a preoccupation with pregnancy and child-rearing. This serves several functions for the sexually abused female adolescent:

1. It may provide an avenue of escape from a sexually abusive home.
2. The teen may see her expected child as someone who will love her. Often she expresses her commitment to "make sure" her child is not abused as she was.
3. Birth control is generally not used. The lack of control she experienced as an abuse victim has prepared her for powerlessness and inadequate decision-making skills.
4. There is a strong value among abuse victims that abortion is not an option for consideration. Frequently expressed sentiments such as "I have to

does not support the claim that teenagers view abortion as a method of birth control. A small percentage of abortions are repeats (11% in Maine).

Teenagers who choose delivery rather than abortion are likely to have the following characteristics:

- low socioeconomic status; while aborters and their partners are more likely to come from middle class backgrounds
- one-parent households, or large family older teenagers
- siblings who were pregnant as teens; while aborters were more likely to have a sister who terminated a pregnancy
- more religious
- conservative views on abortion
- poor school performance, or high school drop-out
- low educational and occupational aspirations
- low self-concept and self-confidence
- less sense of control over their lives
- traditional views of sex roles
- peer role models (knowing one or more single teenage mothers)
- longer relationships with their partners, though the quality of the relationship is not a factor
- partner having the greatest influence on their pregnancy decision, followed by girlfriends, mother, physician, clergy and father having decreasing degrees of influence. Aborters received support from their decision from their physician, best girlfriend, mother, father and lastly from their partners. (Flick, 1986)

Again, the summary of factors influencing whether a pregnant teen aborts or delivers suggests that the teenager with fewer options for her future due to poor academic performance, low self-esteem, poverty or little sense of control over her life is more likely to become a teenager parent.

decision point 4. adoption or parenthood

Of those teenagers who carry their pregnancy to term, very few choose adoption for their baby. In the 50's and 60's when there was a greater stigma associated with adolescent parenthood, adoption was more frequently chosen. In addition to the 4% of teenagers who choose a formal adoption through either a public or private agency, probably about 6% of the babies born to teenagers are taken into the extended family, or informally adopted. Data on this practice in Maine is not available. Of the teenage mothers currently in Maine, about one-half are single, and one-third are on AFDC. It is probable that those remaining single teenage mothers who are not receiving welfare continue to live in their parents' home, and in some cases their baby may be informally adopted by the grandmother. Other families may simply continue to provide a home for the new mother and her baby, and provide her with assistance in meeting her parenting responsibilities while she continues her education.

The Task Force was concerned that formal adoption is seldom considered a viable option among teens today. An increase in counseling, education and public information efforts is necessary to improve the knowledge and attitudes about adoption. New statutes and practices are needed, pending the thorough study of current conditions. The last formal study of adoption laws and practices in Maine occurred in 1963.

The national research shows that teenagers who choose to become parents rather than choosing adoption are likely to have the following characteristics:

- younger
- lower socioeconomic status
- greater chance of coming from one-parent family
- relationships with their parents meet their needs less well than teenagers choosing adoption
- less education, less likely to be enrolled in school
- less traditional views about family life
- longer relationship with the baby's father, and more influenced by him than teenagers choosing adoption (Flick, 1986)

Again, the summary suggests that teens with the fewest options for the future, and therefore with less to protect them from the demands of early parenthood, are the ones who are more likely to become parents. They may also be seeking to fill an emotional gap in their lives due to poverty, and poor family relationships. Others who never intended to get pregnant reject all other options, abortion, adoption, marriage and raise their child regardless of the impact on their future plans.

take my medicine," seems to indicate that the teen may see herself as deserving of the "punishment" of bearing a child.

5. Adoption is also infrequently chosen. Among the reasons are the decrease in social stigma of being a single parent. But some pregnant teens who were sexual abuse victims express anxiety about prospective adoptive parents. A high number of sexually abused youth have had negative experiences in foster care themselves, or were sexually abused by foster parents, or even adoptive parents.

It is important to emphasize that children of sexually abused mothers are at high risk for abuse themselves. Untreated and unresolved, the abuse cycle replicates itself, and the young mother may choose a potentially abusive partner. There is often a deficit in bonding between these young mothers and their children, as the girl realizes that her dreams of being "loved" by her child are not materializing. The anxiety, rage and insecurity of the young mother are projected onto the infant or young child. Comments such as "he's a nervous baby," "she looks at me funny," "I know she doesn't want to be held" are typical and form the basis for potential child abuse and neglect.

Definitive data on the frequency of sexual abuse among teen mothers is not known. Workers in programs for high risk teens including teens on AFDC report a significant number of their clients have been victims of sexual abuse.

One program in Maine provides some disturbing statistics.

(The Street Program is a sex abuse project in Portland, Maine. Housed at the YWCA, its clients must be under 21 years of age, without a stable living situation or legal means of income, and "street-connected." Street life is characterized by prostitution, substance abuse, and violence. Youth often have a history of multiple out-of-home placements and generally are drop-outs.)

Of the 179 clients served in one year, 65 were female with an average age of 17.4 (youngest 12, oldest 21). Of these females 52% were self-reported sexual abuse victims; 48% were or had been in State custody and 30.7% of these females were pregnant or already had at least one child, some as old as 5 years. The average age of the pregnant and parenting teen was 18.3, with the youngest 14.

Of the pregnant and parenting teens:

85% were known sexual abuse victims
10% were married
85% single
5% divorced
10% were given for adoption
100% of those pregnant were intending to keep the child
25% of the children of teen parents were in foster care

links with substance use/abuse

Teenage sexual activity, and alcohol and drug use have much in common. study of high school and college women found that high school virgins used marijuana and alcohol less than sexually experienced teens. (Jessor & Jessor, 1975) In addition, it found that the greater the involvement with marijuana or alcohol use, the greater the likelihood of early sexual activity. These behaviors are seen to be components in a syndrome of unconventional, nonconforming social problem behaviors that includes early onset of drinking, problem drinking, marijuana and other illicit drug use, early sexual activity, delinquent behavior, problem school behavior, and other antisocial behaviors. (Jessor, 1979)

In fact, teenagers who become adolescent parents and those who are alcohol/drug abusers share a number of characteristics:

- they value independence and unconventional behavior
- they value peer influence over their parents' views
- they have low self-esteem and academic accomplishment
- they have poor communication with their parents and perceive family relationships to be less important or close
- they perceive that they are not vulnerable to the hazards of risk-taking behavior

These findings point to the need for generic prevention strategies which link efforts to delay both early sexual activity and early alcohol/drug use. Such efforts could increase students' general self-esteem and social competence in order to reach the roots underlying both kinds of problem behavior. Of particular interest are those efforts to delay the beginning of alcohol use among young people, helping them to develop what are referred to as "resistance skills." Delaying the onset of drinking would delay the onset of other behaviors such as substance abuse and early sexual activity, having an impact on adolescent pregnancy. (Wilsnack, 1978)

What is clear in examining some of the linkages between the two kinds of problem behavior is that adolescents need close relationships. If their needs are not met in the family, they will go elsewhere and often engage in anti-social or "acting out" behavior. As one specialist in adolescent medicine writes, "In 1985 American families are not supplying teenagers with enough fulfillment." (Strasburger, 1985)

teens who marry

The risks to teen females who become single parents are clear in the prevalence of low birth-weight babies, lower educational attainment, lower earning potential, increased welfare dependency, and emotional problems in adjusting to the demands of being a parent at the time in her life when she is still developing her own identity and independence.

Yet, fewer and fewer pregnant teenagers choose to marry before their baby is born. There is less stigma today about being a single parent. Changing family structures, high divorce rates and the prevalence of unmarried couples living together all influence teenagers that marriage may not be the answer if an unplanned pregnancy occurs. In the past, many teenagers married and began to raise a family at early ages. But with increased expectations for education and career preparation, early marriage and parenting are less frequently chosen. Data is not available in Maine to tell how many of the teenage women who were married at the time their baby was born got married before or after conception.

Teenagers who marry face the dual challenge of adjusting to new roles as parent and spouse, while completing the developmental tasks of adolescence. In addition, it is likely that they have been rejected by their own parents and so lack one of the basic supports that might help them through the transition. Statistics indicate a number of risks associated with this group of young adults.

First, there is a greater tendency that the young woman will have a second child within two years than if she had remained unmarried — due to the availability of sex and the expectations of raising a family. The short interval between births increases risk of continued welfare dependency, a reduced ability to accumulate financial assets, and increased risks of stillbirth, prematurity and neonatal mortality. In addition, teenage girls who marry in response to a pregnancy are less likely to resume their education than those who remain unmarried. In 1981, less than one-fifth of teens who married prior to their 18th birthday ever finished high school. This is probably due to the fact that many young women who don't marry remain in the homes of their parents, who may offer support to continue her education. (This impact of marriage on education is much stronger among black than among white teenagers.)

Married teenagers have a high risk of divorce. One in five couples will break up within the first year; one in three within two years. According to U.S. Census data, teens are twice as likely to dissolve their marriages as couples who marry in their twenties. The younger the teen is when she marries, the more likely she will be divorced. After 10 years of marriage, women who married at ages 14-17 have three times the likelihood, and women who married at 18-19 have twice the likelihood of being divorced as women who married at ages 20-24. While most teenagers who marry will experience a divorce, it is important to recognize that divorce is not only a problem for this age group. Young people grow up in a world in which marital instability is a norm. Divorce is a problem of the entire culture. While this problem may increase among teenage marriages, the responsibility for it rests with adults as well.

Young women who marry prior to childbirth — whether before or after conception — experience much greater marital stability in later years than do those who delay marriage until after the birth. Fathers who

participate in the birth are less likely to separate than fathers who are not involved in the birth and bonding.

Given the risks of marriage for the very young teenager, it seems that marriage for the pregnant teenager under age 17 should be carefully considered. Counseling should be mandatory and ongoing for both partners. Older adolescents considering marriage can also benefit from the assistance of a counselor or clergy member so that the decision is thoughtfully made. Pregnancy alone is not a sufficient reason for marriage. If the marriage is going to occur, the research suggests that steps should be taken to encourage it to take place before the birth of the child, as this improves the chances of the marriage lasting. In fact, their chances are just as good as teenage marriages which occur before the woman becomes pregnant.

the single teenage parent

The majority of teenage pregnancies in Maine are among single women with the mother choosing to raise the child herself. The health and economic risks are high for this group, although those whose families offer support to the new mother have a better chance of continuing their education and adolescent development. Some studies suggest that the quality of mothering which teens provide depends not as much on age as on the mother's family supports. For example, teen mothers living with their own mothers appear to nurture their babies more than teens who are alone with their babies. Most young mothers tend to be slower in responding to their baby's needs and less verbal with their babies than older mothers (Simpkins, 1984) and they tend to be prone to depression. (Colletta, 1983)

In an effort to develop a clearer picture of the single teenage mothers in Maine, the Task Force look at the clients of the Family Services program (FSP) of the Department of Human Services. This program began in 1983 to assist single teenage mothers who are receiving welfare (AFDC). It serves about 50% of these families, many of whom suffer from not only extreme financial limitations, but face such additional obstacles as: unemployment, lack of education, unsafe housing and chronic health problems. These stresses often lead to other problems, including an inability to properly care for children, which results in the problems being passed from one generation to the next.

The Family Service program is voluntary. High risk teens are contacted by the program as they become known to the Department through AFDC and through referrals of AFDC clients. The program can maintain clients even after their AFDC status is terminated to make the transition to self-sufficiency more successful.

There are 547 clients served in the FSP's second year and an additional 314 individuals were contacted but chose not to participate. The living arrangments of all those contacted were found to be:

living arrangements by age category

	Age 14-17	Age 18-21
Alone (prior to birth of child	6	26
One-Parent Family	69	431
Two-Parent Family	7	26
With Relatives	56	146
With Non-Relatives	21	38
Foster Home	0	3
Unknown	3	6
Totals	162	676

The number of single teenage mothers living as one parent families has increased, while the number living with relatives has decreased. This is due to a revision of federal AFDC guidelines requiring that young mothers who live with their families must report the income of the entire household when applying for AFDC. The impact of this shift in living arrangement for 14-17 year old mother is of particular concern.

Seventy-three percent of all the individuals contacted have never been married, with the percentage who have been married increasing with age.

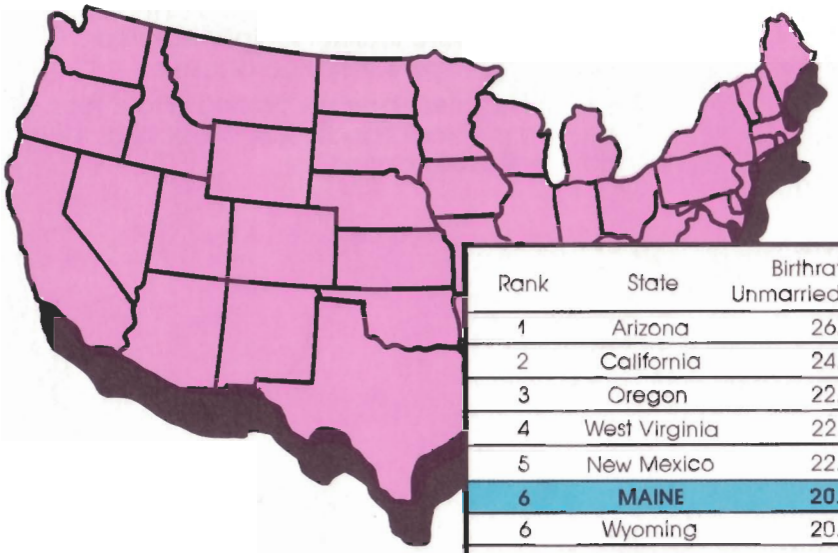
In addition, when clients entered the program they were experiencing a number of other barriers to self-suffieciency:

40% were experiencing an emotional crisis
28% were feeling socially isolated
11% were substance abusers

Other client barriers among single teen mothers included physical handicaps, physical or mental illness and mental retardation.

Graphic 1

birth rates for unmarried mothers, age 15-19, having a white race child, 1980. (rates per 1000 unmarried women residing in area for age group.)



Rank	State	Birthrate for Unmarried Mothers	Rank	State	Birthrate for Unmarried Mothers
1	Arizona	26.1	23	Wisconsin	15.5
2	California	24.4	24	New Hampshire	15.4
3	Oregon	22.5	25	Minnesota	15.3
4	West Virginia	22.1	26	Nevada	14.8
5	New Mexico	22.0	27	Delaware	14.5
6	**MAINE**	**20.5**	28	Tennessee	14.4
6	Wyoming	20.5	29	Rhode Island	14.3
7	Kentucky	20.4	30	Louisiana	14.2
8	Colorado	19.8	31	Florida	13.9
9	Washington	19.0	32	New York	13.8
10	Vermont	18.2	32	Pennsylvania	13.8
11	Utah	18.1	33	Massachusetts	13.7
12	Idaho	17.9	34	Michigan	13.5
13	Ohio	17.7	34	North Dakota	13.5
14	Alaska	17.6	35	Maryland	12.9
15	Oklahoma	17.5	36	South Carolina	12.6
16	Texas	17.3	37	Mississippi	12.4
17	Indiana	17.2	38	Connecticut	11.8
18	Kansas	16.9	39	Hawaii	11.7
19	Arkansas	16.7	39	Virginia	11.7
20	Missouri	16.5	40	New Jersey	11.5
20	Montana	16.5	41	Georgia	11.3
20	Nebraska	16.5	42	Alabama	10.9
21	Illinois	15.9	43	North Carolina	10.7
22	Iowa	15.6	44	District of Columbia	8.3
23	South Dakota	15.5		**United States**	**16.2**

Source of Data: National Center for Health Statistics, U.S. Department of Health and Human Services.

Graphic 2

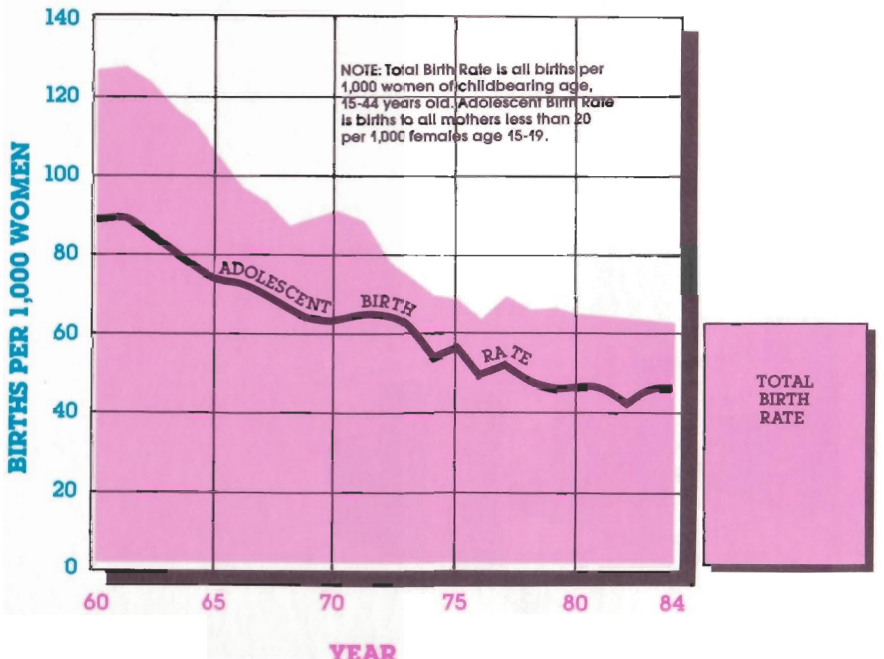
pregnancies by outcome: live births, fetal deaths, miscarriages, and induced abortions by age of teen, maine, 1984.

Age of Woman	Estimate of Total Pregnancies	Live Births		Fetal Deaths		Spontaneous Abortions		Induced Abortions	
		Number of Births	Percent of Total Pregnancies	Number of Deaths	Percent of Total Pregnancies	Number of Spontaneous Abortions	Percent of Total Pregnancies	Number of Induced Abortions	Percent of Total Pregnancies
Total-All Ages	21,032	16,631	79.1%	113	0.5%	521	2.5%	3,767	17.9%
Age 20 & Older	17,737	14,601	82.3	93	0.5	434	2.4	2,619	14.8
Age Under 15	52	17	32.7	0	0.0	3	5.8	32	61.5
Age 15	167	73	43.7	2	1.2	4	2.4	88	52.7
Age 16	368	189	51.4	0	0.0	10	2.7	169	45.9
Age 17	578	330	57.1	1	0.2	13	2.2	234	40.5
Age 18	929	575	61.9	8	0.9	18	1.9	328	35.3
Age 19	1,191	846	71.0	9	0.8	39	3.3	297	24.9
Total — Teens	3,285	2,030	61.8	20	0.6	87	2.6	1,148	34.9

NOTE: A small number of events for which Age of Woman is unknown are included in the Total-All Ages and the Age 20 Older categories. Fetal deaths are of 20 weeks of gestation or more; deaths of less than 20 weeks of gestation are considered as miscarriages. For the purposes of this table, the number of Total Pregnancies is estimated at the sum of Live Births, Fetal Deaths, Miscarriages (Spontaneous Abortions), and Induced Abortions. The count of rare events (such as fetal deaths to 15-year olds) can vary widely from year to year, and should therefore be interpreted cautiously.

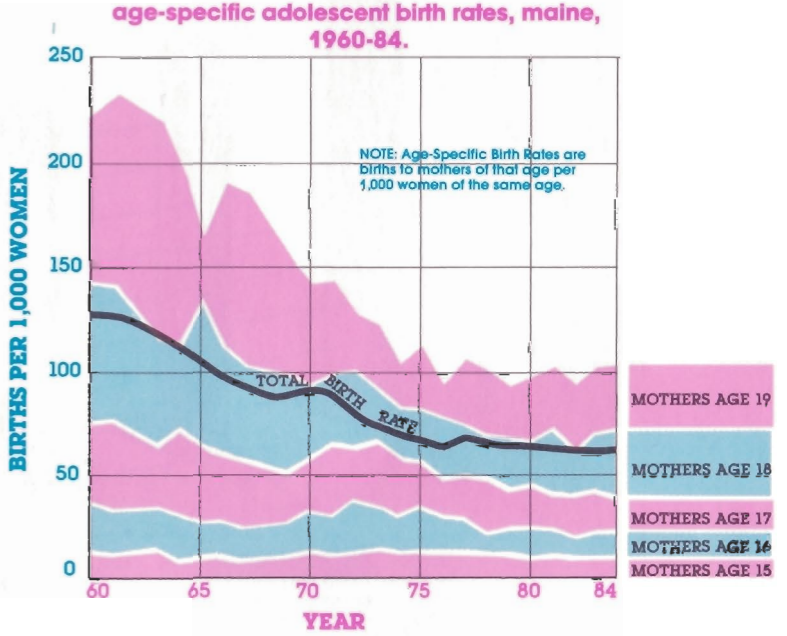
Graphic 3

total and adolescent birth rates, maine 1960-1984.



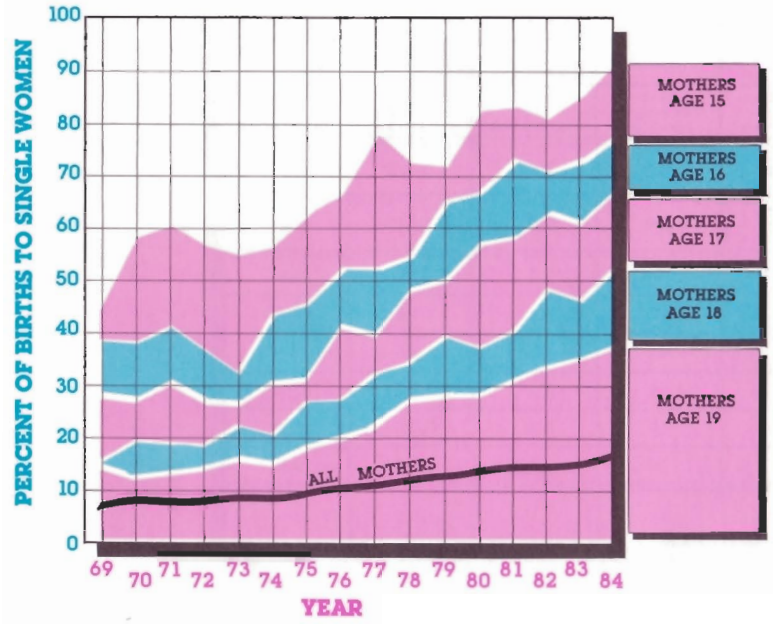
Graphic 4

age-specific adolescent birth rates, maine, 1960-84.



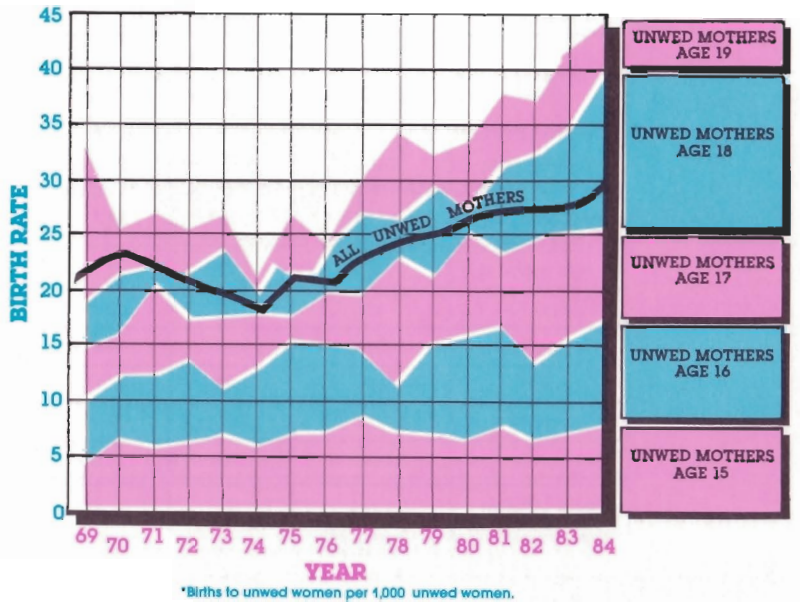
Graphic 5

percent of births to single mothers to total births by age of mother, maine, 1969-84.



Graphic 6

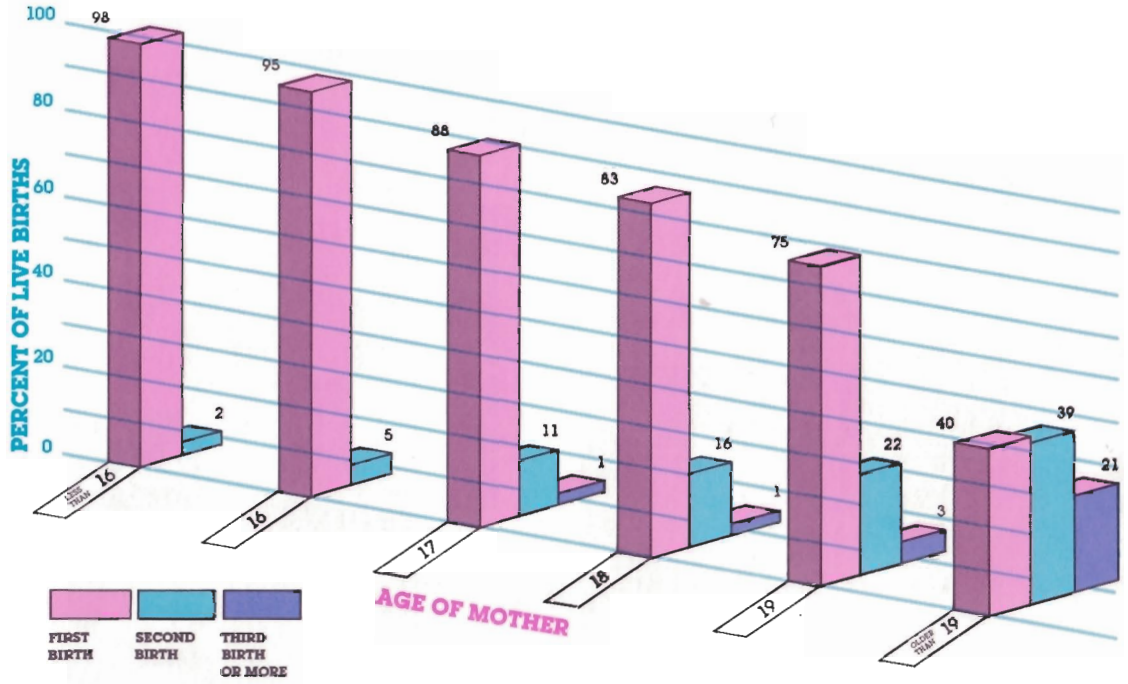
age-specific total and adolescent birth rates to unwed mothers, maine, 1969-84.



*Births to unwed women per 1,000 unwed women.

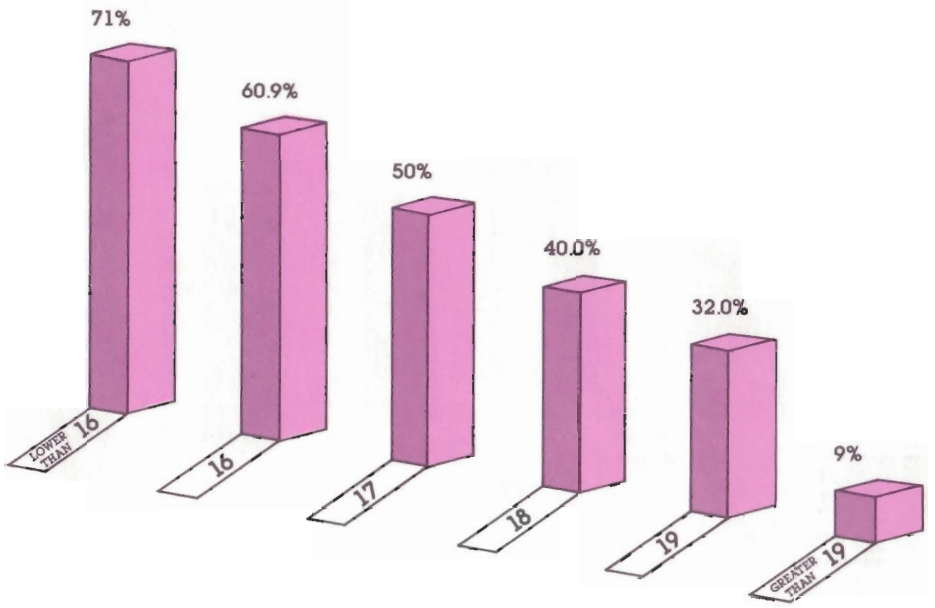
Graphic 7

percent of live births by mother's previous live births by age of mother, maine, 1984.



Graphic 8

percent of live births by age of mother for which age of father is unknown



Graphic 9

live births to adolescent mothers: age of mother by age of father, maine, 1985.

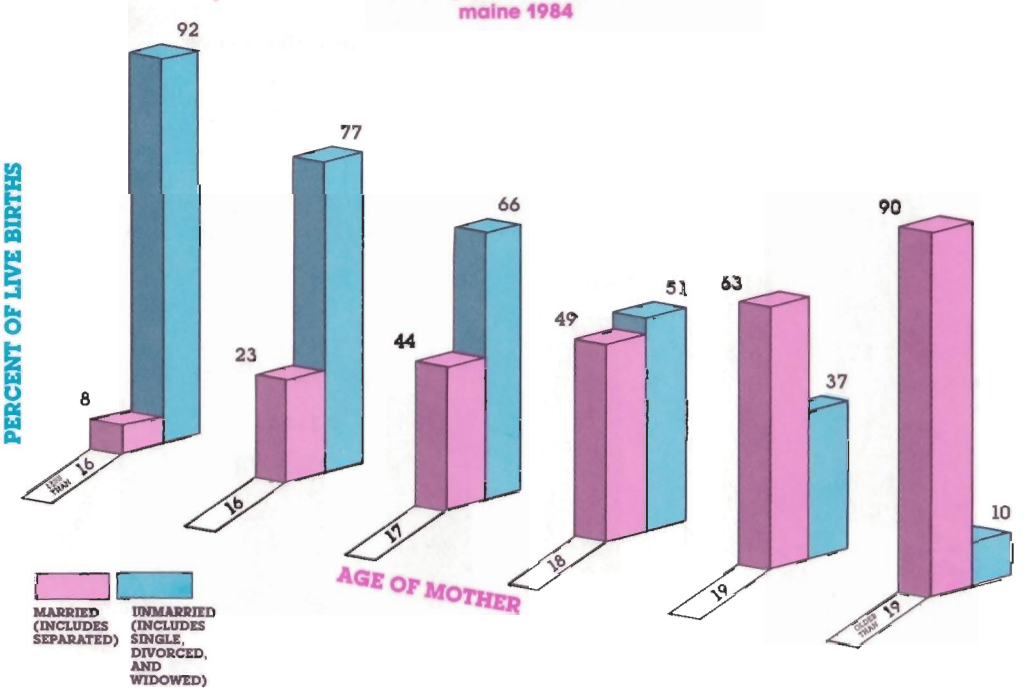
AGE OF FATHER

AGE OF MOTHER	14	15	16	17	18	19	20-24	25+	Unknown	%	TOTAL
12									1	100	1
13									1	100	1
14				2			2		12	75	16
15	1		1	3	4	2	4	3	40	69	58
16		1	3	4	16	15	29	4	112	60.9	184
17			3	11	27	39	86	17	184	50.1	367
18		2	2	10	27	52	193	52	225	40.1	563
19				2	15	41	371	107	251	31.9	787

**Source: 1985 Computerized Birth File.
Table Prepared by: Office of Data, Research and Vital Statistics, Maine Department of Human Services, May, 1986.

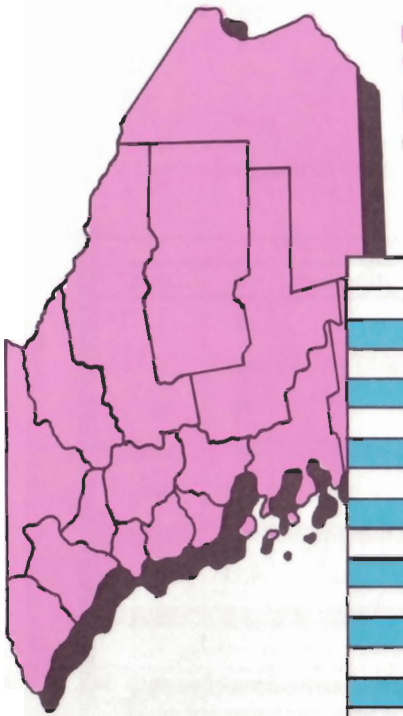
Graphic 10

percent of live births by age of mother by mother's marital status, maine 1984



Graphic 11

maine counties ranked by teenage birth rate, teenage abortion rate and teenage pregnancy rate, 1984.



NOTE: Birth rate calculated as number of live births per 1000 females age 15-19.
Abortion rate calculated as number of induced abortions per 1000 females age 15-19.
Pregnancy rate calculated as number of births plus number of induced abortions per 1000 females age 15-19.

Counties	Birth	Abortion	Pregnancy
Washington	79.8	Cumberland 37.7	Washington 111.9
Piscataquis	66.7	Lincoln 33.7	Knox 95.3
Knox	66.0	Washington 32.1	Somerset 88.6
Somerset	65.2	Hancock 31.2	Hancock 83.3
Andro.	57.1	Kennebec 29.6	Andro. 82.1
Franklin	54.1	Knox 29.2	Piscataquis 81.7
Hancock	52.1	Waldo 27.6	Lincoln 78.9
Aroostook	51.3	Sagadahoc 27.2	Kennebec 75.2
	Statewide 47.5	Statewide 26.9	Statewide 74.4
Penobscot	47.2	Andro. 25.0	Cumberland 74.3
Waldo	46.7	Penobscot 24.4	Waldo 74.3
Kennebec	45.5	Somerset 23.4	Penobscot 71.6
Lincoln	45.3	York 21.1	Franklin 69.4
Oxford	43.0	Oxford 19.2	Aroostook 68.6
York	40.9	Aroostook 17.3	Sagadahoc 64.9
Sagadahoc	37.7	Franklin 15.3	Oxford 62.2
Cumberland	36.5	Piscataquis 15.0	York 62.0

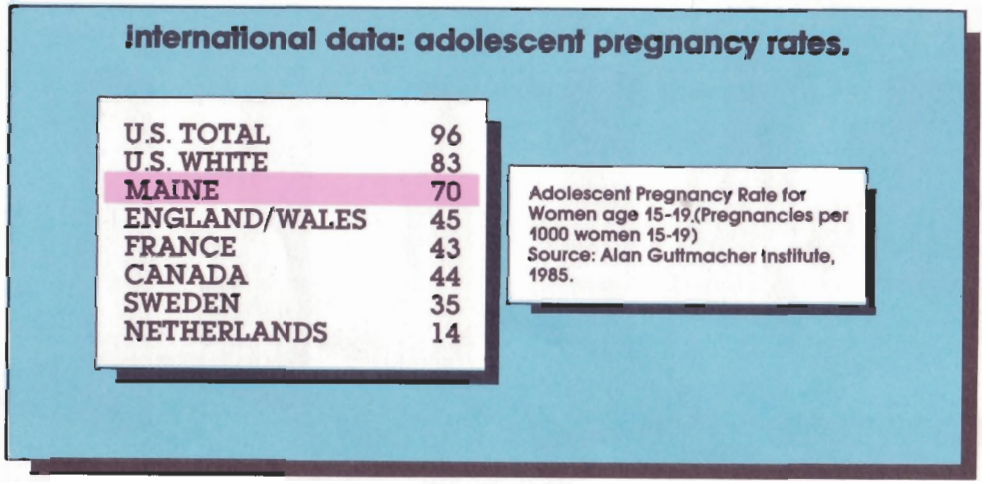
Graphic 12

induced abortions by age, maine counties, 1984.

County	Total Abortions All Ages	Ages 15-19	Abortion Rate for Teens*	Teenage Abortions as Percentage of Total Abortions — All ages
Androscoggin	278	95	25.0	34%
Aroostook	174	58	17.3	33%
Cumberland	1,178	317	37.7	27%
Franklin	47	17	15.3	36%
Hancock	176	45	31.2	26%
Kennebec	408	123	29.6	30%
Knox	122	31	29.2	25%
Lincoln	112	32	33.7	29%
Oxford	77	33	19.2	43%
Penobscot	429	133	24.4	31%
Piscataquis	38	9	15.0	24%
Sagadahoc	121	31	27.2	26%
Somerset	104	43	23.4	41%
Waldo	81	29	27.6	36%
Washington	96	35	32.1	36%
York	325	117	21.1	36%
State Totals	3766	1148	26.9	30%

*Number of induced abortions per 1000 females, age 15-19.

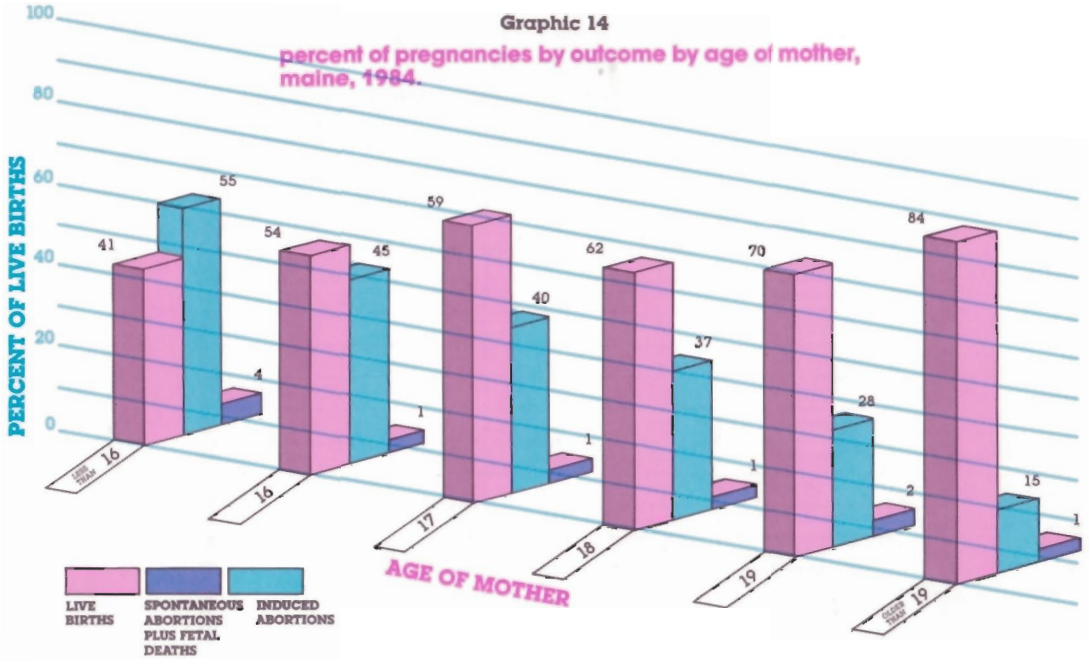
Repeat abortions appear to account for a small percentage of cases. Of the total induced abortions among teens in 1984, a reported 11% had already had an abortion; 6% had had a previous live birth.



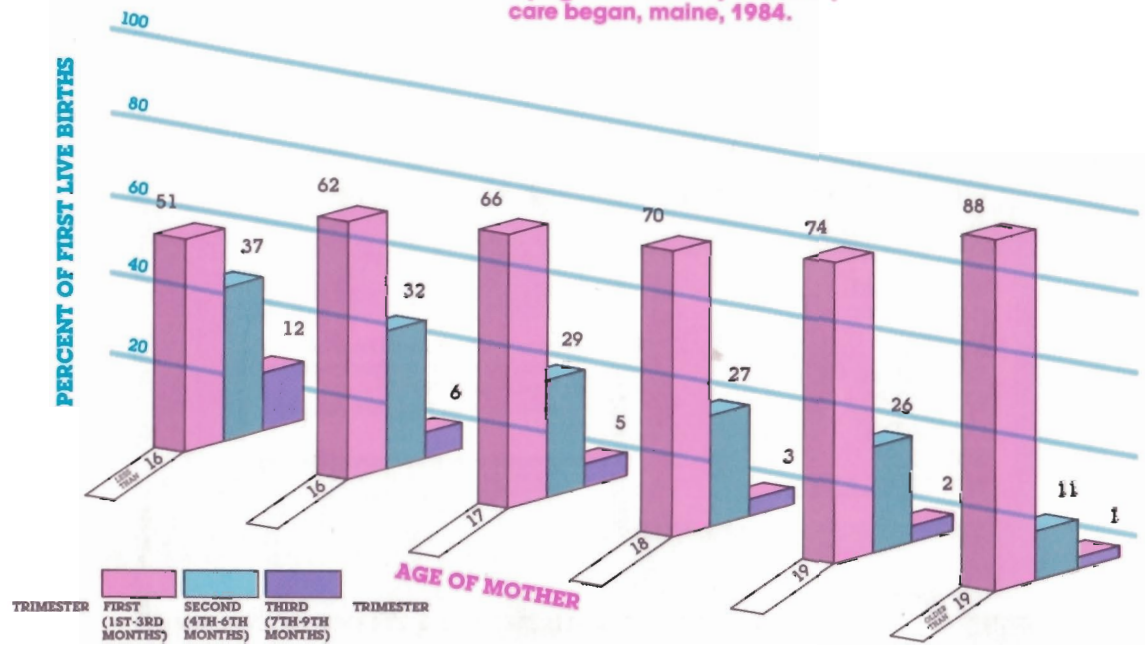
Graphic 13

Graphic 14

percent of pregnancies by outcome by age of mother, maine, 1984.



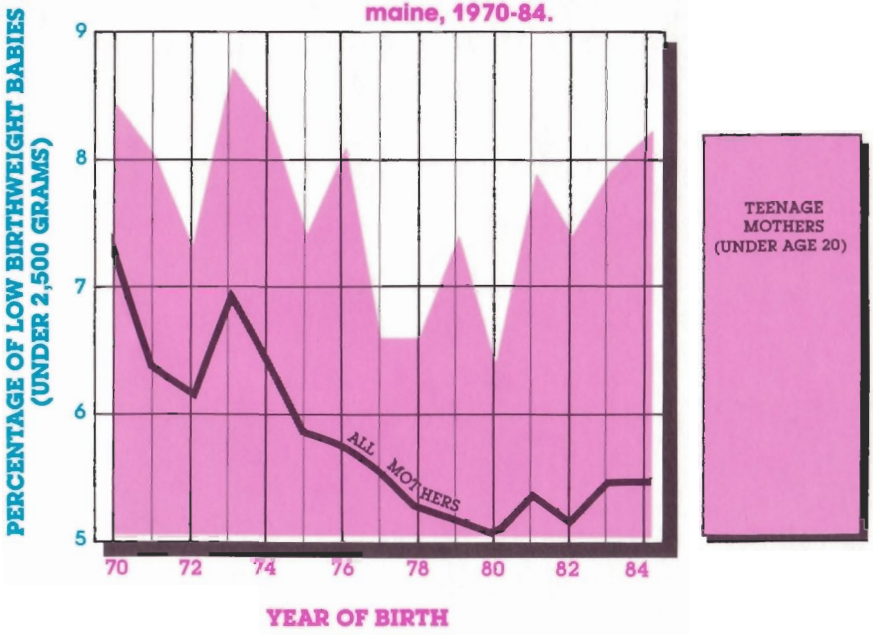
first live births by age of mother by trimester prenatal care began, maine, 1984.



Graphic 15

Graphic 16

percent of low birthweight babies for all and for teenage mothers, maine, 1970-84.



All chart and graph information
Source of Data: 1984 Birth Certificate Data File, Office of Health Planning and Development.
Chart Prepared by: Division of Data and Research, Office of Health Planning and Development, Bureau of Medical Services, Maine Department of Human Services, November, 1985.
unless otherwise noted.

the issues

teenage pregnancy in pluralistic society

The Task Force has been told that there are as many reasons why a teenager gets pregnant as there are teenagers. If you were to poll every teenager who has been pregnant, you might find that is true.

There are a number of conflicting but strongly-held beliefs among adults about the most effective ways to prevent teen pregnancy and parenting. Those differences existed among our members, as well as among the parents, teens and professionals who attended our public forums. However, despite the differences, there is one fact on which everyone agrees: pregnancy and parenting are needless risks to a teen's well-being, to the future of the child and to society as a whole. We believe that unintended, teenage pregnancy and parenting must be prevented.

What then, if we all agree about the problem, makes addressing the prevention of teen pregnancy so controversial.

One reason is that we live in a pluralistic society.

Nowhere is it more evident that life is composed of a multiplicity of principles and beliefs than in the area of adolescent sexuality and sexual activity. It is a subject riddled with intimate personal, cultural, religious and moral issues.

Yet adolescent sexuality in itself is not the problem. It becomes a problem only when we do not understand it. By definition:

Sexuality is a function of the total personality, not limited to gender identity or to genital reproductive processes. It is an aspect of personality which develops throughout life as part of the whole self involving body images, roles in the family, self-perception, social interactions, sexual preference and emotions, and the feelings, touching, and looks of love. (See Section: Sex, Sexual, Sexuality, What Does It Mean?)

What is a problem for most adults is adolescent sexual intercourse, which the Task Force defines as sexual activity. Generally, most controversy centers around the point (age, marital status, maturity) at which sexual activity, pregnancy and parenting among teens is acceptable, and the strategies applied to the prevention of adolescent pregnancy.

What are the range of opinions, beliefs and convictions?

To define the diversity of views in Maine and to understand the work of the Task Force, the following profiles are presented as a cross section of Maine parents and teens. We want to show you, the public, how different some of these beliefs appear to be. No two families are alike in Maine, nor are they entirely different; in each there exists both unique and similar qualities. However, the following descriptions serve largely as examples of separate and distinct points of view. These examples are taken from responses offered at the public forums by parents and teens and from letters written about Task Force work.

parents' beliefs

Most parents have very clear personal, moral, or religious convictions that dictate the appropriate time at which they consider sexual activity an acceptable behavior for their teenagers.

They want their teenagers to wait to have sex until it is "right" — morally, or, until they are physically and emotionally "ready." Parents define readiness differently for their own teens: married, involved in a long term love relationship, responsible about contraceptives, prepared to accept the risks of contraceptive failure, able to make the decision for themselves, independent of their parents, and so on.

These are the ideal families in which communication is not a problem. Parents communicate their values to

their teens and in turn model the behavior they expect from them. Teens feel comfortable talking to their parents about sex and about their developing values.

Generally, we believe that the teens in these families are among the majority who abstain from sexual activity as well as those teens who are sexually active and prevent pregnancy.

Some parents we heard about do not make a decision about the appropriateness of sexual activity for their teens. Thus, they fail to communicate their expectations and values. Teens may learn from the examples their parents set, but there is no one to help them cope with peer pressure or understand the confusing messages they receive from advertising, music, television and movies. Some of these parents ignore the problem of teen sexual activity and pregnancy, hoping it will go away.

There are other families that simply do not know how to communicate directly with their children about sex.

"My parents never talked to me about sex, . . I'm a boy and I guess they thought I knew everything. I was in the eleventh grade before I got anything from school."

"I'm 17 and I have an eight month old son now. Parents either tell you not to do 'it', or else they just don't say anything and figure you'll get it in sex ed. Thank God for sex ed classes or I'd have had a kid when I was 14."

Among the parents who have strong beliefs about adolescent sexuality are those who believe in "sexual purity for teenagers," based on a system of fundamental rights and wrongs.

"Chastity is the only answer." (It) was one sure method of birth control throughout the history of civilization. Only 25 years ago did the sexual revolutionaries develop a different approach. They've had the opportunity to provide their permissive methods and the victims of its failure litter the cultural and medical landscape."

"Giving birth to a child is the greatest thing on earth — but in marriage only. Giving birth in teen years without marriage and unable to take the responsibilities of parenthood is a deviation of natural and moral law and should be clearly condemned."

Some parents believe that the decision to have sex is a personal decision belonging to their teen. Throughout their child's life they work to prepare the teen for a responsible decision about sexual activity and pregnancy: They provide open communication, accurate information, a supportive home life, reinforcement for positive self-esteem and encouragement to build aspirations for the future. If their teen chooses sexual activity during adolescence, these parents generally support the use of contraceptives to protect their teen from an unintended pregnancy and teen parenting. They believe,

"There are adolescents who are having responsible sex with one another and who are healthy."

sex education

The issue of sex education in schools evokes strong opinions.

"At the very least, it should be apparent that sex education in our public schools has failed to act as a sufficient deterrent to the 'sexual holocaust'. At the very worst, it is an accessory to the crisis."

"As long as you teach about pregnancy, you will get pregnancy; just as it is true that as long as you teach about drug abuse, it will flourish."

Opinions to the contrary are as strong:

"The availability of information and the encouragement of discussion and values clarification is not tantamount to encouraging permissiveness and promiscuity. The most sexually active teenagers that I have met in my work (child psychiatry and incarcerated youth) were ironically the very least informed about sexual and contraceptive physiology."

"A complete knowledge of sexual and reproductive activities empower women's choices."

"Parents who, uncomfortable with their own sexuality and unwilling to address the issue of responsible sexual behavior with their own children at home, nonetheless refuse to allow formal educational efforts on sexuality to be undertaken in schools or other settings."

contraceptives

Others believe that contraceptives encourage sexual activity by their knowledge and availability.

"Hey kids, you are going to do it, so this is what you would do. We will make the pill readily available and condom and whatever and show you how to use them: Isn't this an encouragement to our youth to take part in irresponsible and immoral sex activity which they are not mature enough to handle?"

Yet, there are teens who say they know about contraceptives but won't use them.

"Teens are scared to get birth control even though they know what the consequences are. They're afraid their parents will find out."

"Parents have to realize that if a kid is ready for sex they are going to do it, contraceptives or not."

motivation for pregnancy

Some adults think the problem goes beyond sex and contraception.

"Many girls are getting pregnant, not because they are having sex (and not using contraceptives) but because they want to get pregnant. These are issues related to family structure and values, not contraception."

"I wanted to get pregnant. Everyone I ever loved left me: My dad left, my grandmother died. Now I'm pregnant and I know there's someone who won't leave me until he's at least 18. We're going to have each other and love each other."

"I want something to fill the empty space inside."

parents' response to pregnancy

Some parents may accept their teen's pregnancy and childbirth into their homes, almost with a sense of anticipation. They, themselves, or other members of their families, may have been teen parents or married young. For these families, early parenting seems normal. The pregnancy and parenting may appear to have few negative consequences due to family support offered to the teen parent and child: a home, assistance in childrearing and child care, income support, health care. Conversely, most homes are ill equipped to support the teen and child; the pregnancy during adolescence thrusts the teen into economic and personal despair.

Other parents are so opposed to the pregnancy that they reject the teen and offer no emotional or economic support. These teens find themselves without housing and medical care — for them life suddenly becomes a struggle to survive.

"I am a 17 year old girl who has a beautiful, healthy, 4 month old son, who is not undernourished or under loved. I quit school BEFORE I became pregnant and I do regret it, but I am going to night school to finish my education. We don't have any money, but we've got lots of love, and they say 'love can get you through times with no money, better than money can get you through times with no love.' Whenever I sit there feeding my baby with only a quarter in my pocket I think of this."

There are other teens who were not living with their families before their pregnancy. They had either run away from a severe family situation in which they were in danger, alienated or neglected, or they were in State custody as a result of physical or sexual abuse.

One young teen shared her experience in a letter to her father:

"Dear Dad,

All through the years I grew up I thought if I was to be a good daughter I had to give you something! I felt I had to repay you for adopting me! I lost one set of parents when I was 3 years old and I lost my second set of parents when I was 8 years old! That's when the abuse started and I lost you as a father, but I gained you as a lover!

I'm 18 years old now and I have a little baby on the way. I'll never have my kid treated the way YOU treated me!"

Other teens help us to see that they are "victims — not villains."

"I am a teen parent of a gorgeous 15 month old daughter. I had her at age 18. I also have many friends who had very normal pregnancies. Do you give us any credit? No, you overlook us. I give my all to my baby! If you do have any concern for us, help us don't cut us down! We are not the villains we are the victims. I chose to keep my baby, and I do the best I can! I will never regret that choice. I knew I would not have it easy, but I was gonna do my damn hardest and give her and I the best life possible. I chose not to marry because her father was a drug addict. He did not care about us! And no I did not finish high school, cause I was scared and confused what people would say and do. I also knew I had to look for help for a life for my baby when she would be born. I went on AFDC/food stamps because I didn't have anywhere else to turn then. I had a 10th grade education, if that. You have no right judging us, because we are young. . ."

supports for teen parents

Some citizens believe that support for teen parents is an incentive for pregnancy.

"Things are too easy and convenient for (teen) mothers. The State gives them AFDC, food stamps, and free rent or subsidized rent, along with a variety of other things. . . .after ONE pregnancy for a single teenage mother, the various agencies that give assistance to these mothers should sit down with them and force them to use some kind of birth control."

Others want to "invest" in programs that help kids.

"Programs that prevent or reduce kid problems make better financial sense to society than paying out to maintain these individuals with welfare checks, prison programs, etc. Human service programs are a good economic investment for society just as real estate, a good education or IRA Accounts."

Others see the need for more "hope."

"We believe that if teens had more hope of finding jobs, establishing careers, and feeling good about their own worth and control in establishing life goals, perhaps they would be seeking gratification through other channels of activity."

religious beliefs

Religious beliefs cause conflict for one teen mother:

"I couldn't use birth control. I mean . . I'm Catholic. I was already committing one sin by having sex. It just seemed to make it worse when I thought of committing another sin on top of that by getting birth control."

The Catholic Church teaches that premarital sex is intrinsically immoral. During the Task Force deliberations about the role of clergy in the prevention of teen pregnancy we sought responses from Maine clergy and religious organizations. Representatives of the Catholic Church offered this response:

". . . the traditional Judeo-Christian teaching (is that) the state of marriage as the proper context for sexual commitment. . .makes human as well as divine sense."

"We recognize that a task force dealing with the issues of teen pregnancy and parenting does not wish to become involved in a debate regarding sexual ethics. The fact is that despite our traditions and our educational efforts, many teens choose to become sexually active. We believe that many factors. . . lead to premature sexual involvement: a lack of consensus regarding sexual values, marriage and family; pressure from a sexually permissive society; and low self-esteem and lack of direction in the lives of many adolescents."

in summary

One worker, from a program for teen parents, sums up much of the diversity the Task Force faced in her description of her clients:

"I have clients who are born-again Christians and I have clients who profess no belief; clients who are from college-educated parents and clients from parents who never completed junior high; clients who have parents and clients who do not."

Regardless of your point of view, regardless of the groups which express their views more eloquently, more aggressively or with more data than others, the fact remains that there is a proponderance of opinion, no simple way to determine who is correct and who is misinformed, whose ideas will work and whose ideas are doomed to failure.

Where did this leave the Task Force?

These sensitive and difficult issues leave us with the dilema common to a democratic, pluralistic society: How do we meet everyone's needs?

How do we balance adolescent rights, needs and responsibilities with those of other family members? How do we complement and build upon the family's own resources rather than substitute or compete with them? How do we care for the pregnant adolescent who is seriously estranged from her famiy? How do we respond to the spiraling divorce rate among teens and the lack of jobs, training, housing, and economic security? Is teen marriage the answer?

Not all teens are the same. How do we incorporate the different needs and behaviors of different age teens in our strategies? A 13-year-old is very different than a 19 year old, and not all 19 year olds are alike. But, is either prepared for responsible decision making?

Finally, how do we promote delaying pregnancy and parenting and at the same time promote the self-esteem of teen parents and provide them with needed resources — without making teen parenthood seem attractive or "easy?"

One thing is clear: all segments of society must become engaged in finding the solutions.

changing families

"The family in its old sense is disappearing from our land, and not only our free institutions are threatened but the very existence of our society is endangered."

The author of this warning was writing in 1859. (Newsweek, 1983) The fear for the life of the family then indicates how long-standing is our concern that family structure should form a stable foundation for society. Today few of us are entering or sustaining the kinds of families our parents had. We are marrying later, having fewer children and divorcing more often, as well as living alone or as unmarried partners more frequently. Family structure has never been etched in stone, though it never fails to be unsettling for parents to see their children arranging their lives differently than they have.

The extended family, which was most common until a few generations ago, grew out of the farm economy, and the needs for self-sufficiency and survival. With a pool of four or five children who survived infancy, perhaps a parent's younger brother or sister, and an elderly parent all living together, it was easy to find a mechanic, babysitter, carpenter, farmhand and nurse within the household. In 1790 the average household included 5.7 persons, including servants and lodgers. In 1967, it was 3.7; and today, 2.75.

In today's largely urban society, most of the needs once fulfilled within an extended family still exist. However, we now pay members of a larger community for the services we used to give each other as members of a family unit. One result of this change is that "we have burdened every small family with tremendous responsibilities once shared within three generations and among a large number of people — the nurturing of small children, the emergence of adolescents into adulthood, the care of the sick and disabled and the protection of the aged." (Mead, 1980)

today's families

Families are increasingly diverse and changing. The divorce rate has been climbing since at least the Civil War. In the 1960's and 1970's, the divorce rate doubled, marriage rate plunged and the birthrate dropped from a twentieth century high following World War II to an all time low. With the acceptance of pre-marital sex, singles increased at an accelerating rate. In 1970, 17.2% of the population were single and living alone. In 1976, the number rose to 20.5%, and in 1981, to 23%. (Senior Scholastic, 1982)

According to the 1980 U. S. Census, only about 4% of households reflect the "ideal" family of the fifties, that of the mother homemaker staying home to raise her children while the breadwinner father leaves each day to earn the family's income. Even the number of children per household has reduced from 2.43 in 1963 to 1.88. Growing numbers of women have taken paying jobs, for reasons of economic necessity as well as personal growth.

In addition, many — 30% — of our households do not have children, either because the households are comprised of older people whose children have left home, or because people have chosen not to have children, or have not had them yet.

More unmarried couples are living together: the numbers tripled from 1970 to 1980, with 27% of these couples having children. We are getting married later as expectations increase for both men and women to devote more time to education and preparation for careers. It is important not to underestimate the revolutionary impact the changes in birth control technology have had on opportunities for women and changing family structure. Control over reproduction has given women greater freedom in choosing when and whether to have children.

"Motherhood was woman's only function, status and identity as well as her biological necessity. It kept her, or was used as an excuse to keep her from education or opportunity to see her abilities in the mainstream of our evolving society. The inequality of women, her second class status in society, was an historical reality linked to that biological state of motherhood." (Friedan, 1981)

While both men and women today have more choices about having children, most do not have a choice about working. It now costs a minimum of $97,000 to raise a child through college, an increase of over $33,000 in just five years. Today the similarity in the activities of males and females are based on economic as much as social or domestic needs.

working women

Nationwide, 60.5% of all women with children under age 18 work. In Maine, in 1985, women represented 45% of the workforce, with 53.3% of Maine women working or looking for work outside the home. In 1950, women represented only 28% of the workforce. This steady rise is similar to national as well as international statistics.

On top of their work outside of the home, women still bear the burden of work inside the home. Of the Maine women working in 1980, 58% of the married women and 73% of the single women had children. Despite a large amount of media attention, fathers are not sharing a significantly greater amount of the burden of homework. Working mothers still hold two jobs, one at home and one at work.

divorce

In the past, property linked men and women in marriage for life. As property was replaced by expectations for emotional and sexual fulfillment in marriages, they became more unstable. Today, one-half of U. S. marriages end in divorce. While some link high divorce rates to an overly liberal society or women's emerging into the workforce, others claim it is a result of men and women taking their lives and their marriages more seriously. (Miller, 1985) It is clear that we have placed many burdens on marriages, expecting couples to take on added obligations with little support from the larger family and community. Three hundred years ago, a couple swearing vows for life were not committing themselves to the half century of togetherness people today can expect. Then, couples were likely to be together for only 20 years before one spouse died. While divorce has increased, today's frequency of remarriage resembles earlier generations when the death of a spouse from illness, childbirth, accident or violence resulted in many remarriages and stepfamilies.

Since the 1970's, households headed by a single mother have doubled; in Maine they have tripled. In 1960, one-twelfth of all children — 5 million children — lived with one parent. From 1975 to 1980, that increased to 10 million, or one-fifth of all children. Yet women on the average earn less than men. A woman returning to the labor force after years spent raising children will be unlikely to obtain anything but an entry level position, or temporary or part-time work.

On the average, women experience a 73% loss of income after divorce, while men find a 42% gain. While the median income of male heads-of-households employed full-time in Maine was $16,200, the median income for female heads-of-households was only $7,500. If we average in the incomes of the 28% of Maine workers who work part-time because there is no other available work, men are earning $10,400 per year, while the female heads-of-households are earning $4,900. Only half (50.5% of women entitled to child support receive full payment, the other half receive partial payment (25%) or no payment at all (24%).

divorce and poverty

A woman's loss of income after divorce often has drastic results. While men leave a marriage better off economically than before, divorce for the woman often forces her into a poverty cycle of low paying jobs and government assistance from which it is difficult to get free. Today, though 62% of single women work, over 3 million divorced and separated women live in poverty with 4.5 million children. One third of all female headed households in Maine are below poverty level. In them are living half of all children in poverty. Although single parent families are only 12% of Maine's families, they comprise over one-third of all poor families. A single parent family is five times as likely to be poor as a two parent family. A teenager who becomes a single mother is seven times more likely to be poor than families with older parents. Eighty percent of children with single mothers under age 25 are poor.

single mothers

Not all single parent families are the result of divorce. Besides having the basic biological option not to have children, women today have the further social option not to get married in order to have children. In 1967, 20% of unmarried women brought their children up alone. In 1973, the number jumped to 55%. In 1980, 80% of the 500,000 U. S. children born to unmarried women went home with their mothers. Again, it is important to remember that an increase in divorce and in unmarried mothers does not necessarily mean a decline in morals. It can also signify a strengthening of a woman's choice to do what she feels is best for her. Just as a woman today is less likely to stay in a marriage that has proven abusive or unsatisfactory, many women no longer feel forced to marry if they become pregnant.

shared parenting

Shared parenting has been a recent adjustment to the increase in divorce. In 1980, just 5 states had a shared parenting option, one preferred it. In 1986, 18 states had a shared parenting option, and 13 preferred it. In Maine, new divorce laws mandate mediation to determine parenting rights and responsibilities and provide progressive ways to establish the best interests of the child. But still, 90% of divorced U. S. mothers have custody of their children.

One-half of these children hadn't seen their fathers in the past year. Though single father families are on the rise, having tripled since 1970, they make up less than 2% of all families with children under 18.

stepfamilies

Remarriage does eventually take a portion of these families out of poverty. Three-fourths of all divorced people will remarry. In fact, the numbers of divorces and remarriages are so high that by 1990 it is estimated that more people will be a part of a second marriage than a first marriage. Yet at this point, the breakup rate of second marriages is 60%. While 1,300 new stepfamilies are formed each day, with 10% of all children under 18 living in stepfamilies, a large percentage of them are likely to break up.

family policy

Working women, the high divorce rate, the prevalence of single mothers and their consequent poverty have created a major change in the family profile. It is a change that our social system has not yet been able to take within its stride. From maternity leave to government supplements to child care, we have few institutions that demonstrate the importance of the family, or even assure the well-being of children in our money conscious society. Yet seventy-five other nations provide such family policies.

In the name of preserving the family, recent administrators have vetoed or ignored the need for child care programs, despite a majority of women with children under six who work. According to a recent report, in nearly one quarter of Maine's households, one or more of the adults was unable to take a job, continue in an education or training program, or was actually forced to quit work because the adult could not find or afford child care. (Child Care in Maine, 1985) The need for child care will continue. In 1990, over 57% of all mothers with children under six will be employed. Sixty-seven percent of all two-

parent families will have both parents in the work force. (Maine State Planning Office, 1986)

In addition to child care, families need solutions such as adequately paid flex time and part-time work for men as well as women.

Despite strong pro-family rhetoric, there are similarly few provisions made for prenatal care, or maternity leave or parental leave. Maternity leave in the United States is treated as a disability. There are no legal provisions guaranteeing the right to a leave for a specific period, guaranteeing wages and the right to return to the job, or health insurance. In 1984, 60% of all working women had no paid "parental leave." (National Commission on Working Women)

In Maine, the numbers of children below the poverty line increased from 14.5% in 1970 to 15.8 percent — 50,000 children — in 1980. While 65% of Maine's poor children receive AFDC, these amounts are not indexed with inflation. In 1978, when the relative amounts provided by AFDC were greater, more poor people, 76% of the poor, qualified for benefits. Now, fewer poor families qualify and those that do receive less real aid, when inflation is taken into account.

We now spend more on defense than on programs for low income families and children. In 1980 we spent $785 per capita on defense, $508 on low income programs. In 1986 we spent $1,100 on defense, $465 on families. In 1990 we will be spending $1,200 on defense and only $401 on families. (Children's Defense Fund, 1986)

The poverty of our children is unique in the western world. In fact, according to Senator Daniel Patrick Moynihan, "The U. S. in the 1980's may be the first society in history in which children are distinctly worse off than adults." (Children's Defense Fund, 1986) Also alone among western nations, we do not have a comprehensive family policy. We now give more social supports to the elderly than to the young since supports to the elderly are protected by the state, while there is no program to protect a child from changes in his or her family.

Yet these programs for families work. In 1963, before several federal programs were initiated or expanded, only 63% of pregnant women began prenatal care in the first trimester. In 1979, that rose to 76%. These children are healthier, more alert, better educated and more skilled. Every dollar spent in early and continuous prenatal care saves $3 to $11 after birth. Yet Medicaid per child has been reduced from $470 in 1979 to $405 in 1983. At the same time, the percentage of poor children receiving Medicaid has also lowered. In 1974, 95% of poor children received Medicaid, in 1979, 88% received it. In 1984, only 75% of poor children received Medicaid. Without these programs, both children and adults face poor health and diminishing futures.

family change not disintegration

The family is changing, it is not disintegrating. The very frequency with which we create new families out of friends and lovers can attest to this. In the 1980 census, the number of unrelated persons living together necessitated a new census category, "persons of the opposite sex sharing living quarters" or POSSLQ's. They make up 3% — 1.9 million — of total households. That, and the number of gay households, has prompted the American Home Economics Association to write a new, open definition of the family:

Two or more persons who share resources, share responsibilities for decisions, share values and goals and have commitments to one another over time. The family is that climate that one comes home to and it is this network of sharing and commitments that most accurately describes the family unit, regardless of blood, legal ties, adoption or marriage.

We really needn't fear the death of families. Human survival depends on alliances and love, and so we need families.

"They're saying that families are dying and soon. They're saying it loud, but we'll see that they're wrong. Families aren't dying. The trouble we take to arrange ourselves in some semblance or other of families is one of the most imperishable habits of the human race. What families are doing in flamboyant and dumbfounding ways, is changing their size and shape and their purpose." (Howard, 1978)

sex, sexual, sexuality — what does it mean?

The first step in improving communication about sexual matters is to understand what sexuality means and when it begins. Sexuality does not begin in adolescence, but with the moment of fertilization when sex differentiation occurs determining either male or female gender. This is the most simple fact of sexuality, but far from the whole story. Sexuality is a function of the total personality, not limited to gender identity or to genital or reproductive processes. It is an aspect of personality which develops throughout life as part of the whole self involving body images, roles in the family, self-perception, social interactions, sexual orientation and feelings, and physical expressions of love. Among the earliest lessons in sexuality that a child receives is the pleasure of closeness with his/her mother. Children also receive messages about what it means to be a boy or a girl. Girls, for instance, tend to receive more touching and hugs, while boys may be encouraged to be more physically independent. In addition to such messages from the family, a child learns about sexuality from peers and the media. Children assemble a sexual identity by either accepting or rejecting the messages, behaviors, values and feelings to which they are exposed. "People become sexual in the same way they become everything else. Without much reflection, they pick up directions from the social environment. They acquire and assemble meanings, skills and values from the people around them." (Gagnon, 1977) It can be said then that sexuality arises from the basic need to reach out and embrace others, and that its expression is culturally learned.

What is defined as "sexual" varies from one culture to another or within the same culture in different historical periods, as do the codes for what sexual behavior is right or wrong. For the Puritans, "the sole purpose of sex was procreation within marriage, and even within marriage sexual relations were thought to be base." (Schiller, 1973) Today in the United States a diversity of sexual behaviors is the norm, with wider acceptance of sexuality as a positive force, a means of enhancing intimacy (marital or not), and an aspect of life in which people want more understanding and freedom. But there is growing awareness and concern about the price these freedoms entail both for families and youth.

In a time of changing sexual behavior and mores among adults, young people are faced with confusing standards. They may feel they deserve the freedom which the media so boldly proclaim. Yet they may lack the information, thinking skills and moral development to understand the consequences and responsibilities of that freedom. As adolescents feel their own bodies changing and developing sexual feelings, they wonder what degree of physical intimacy is right for them. These are normal feelings and concerns of adolescence. It is important to acknowledge that all teenagers are sexual, in the same way that all humans are sexual whether they are children or elderly, divorced, celibate, handicapped or mentally retarded. One need not be sexually involved to be sexual. It is important for adolescents to understand their sexuality as a positive aspect of who they are and as a capability requiring thoughtful decision-making based on ethical values and respect for self and others. This requires giving children and adolescents a sense "about the goodness of all the child's endowments, including sex." (Calderone, 1984)

Educators in sexuality and family life education have increasingly come to emphasize the importance of parents taking responsibility for the sexual development of their children by providing factual information, but also by taking advantage of the opportunities to become their child's "teacher of love." (Carrera, 1985) As one educator writes:

"Throughout the life span, throughout infancy into the later years, the presence of feelings of self-worth, and the ability to express feelings of affection and love to others in appropriate and fulfilling ways, are functions of how love is learned during the earliest years, the degree to which it remains present, and how it is experienced as the young person grows. These combined factors create the child's love endowment. . . .The language of this love, the 'lovemaking' if you will, that is the bedrock of this endowment, are the touches of love, the words of love, the looks of love and other gestures and expressions which convey deep and meaningful affectionate messages to the infant, child and teen, signifying that they are valuable, worthwhile and prized persons and family members." (Carrera, 1985)

Throughout the efforts of the Task Force, we worked with this broad and holistic definition of sexuality as an aspect of personality. The term "sexual activity" has been used in this report to refer specifically to sexual intercourse, whether this has occurred frequently or only once, within a loving and mutually committed relationship or more casually. "Sexually active" is in no way intended to suggest promiscuity or to carry a value judgment. The term is used in this report to address those teens who have already made the decision to become sexually involved and therefore are at increased risk of becoming teen parents. The Task Force focused on this group of teenagers because of their increased risk.

sexual trends and family change

Recent family changes reflect changes in sexual attitudes and conduct. Increased premarital sexual activity, and higher expectations for sex and love within marriage and other significant relationships are aspects of the change. We care more about our sexual relationships and are more comfortable talking with one another about them than our parents were. We tend to be more accepting that our differences as human beings are expressed sexually, among other ways, and view our differences as expressions of diversity rather than deviance.

The automobile, the birth control pill, increased divorce rates and the youth movements of the 1960's all have contributed to growing sexual diversity. The automobile provided opportunities for young people to escape adult supervision. The birth control pill and other contraceptive developments afforded women more control over their own fertility, as well as their careers. The youth movement of the 1960's emphasized the pleasure of sexual freedom. And the rising divorce rate and increase in working mothers meant that young people generally had less supervision at home. They also had more diverse role models, as their divorced parents became involved in new relationships and became less optimistic about marriage. Perhaps some of the most dramatic changes have been brought about by the feminist movement. These include changes in the quality of intimate relationships as women's awareness of their own sexuality and life options have increased. Sex used to be something a man did to a woman. Today women expect and seek their own sexual fulfillment in their intimate relationships, as well as sharing pleasure with their partner.

"In less than a century we have moved from sexuality as reproduction and a pivotal form of conduct in our judgments of good and evil to more diversified and pluralistic versions of its meanings and goals. In the 1970's the emerging purposes of sex are those related to the role of sex and love in the choice of sexual partners, sex as an expression of emotional intimacy, sex as interpersonal competence, and sex as passion and rebellion." (Gagnon, 1977)

The future is likely to offer more diversity, although the increases in premarital intercourse may now be leveling off. The use of contraceptives is likely to become more commonplace. And with the devastating increase in sexually transmitted diseases, particularly AIDS, more responsibility, commitment and monogamy will be encouraged. As more women work and have an income of their own, the reasons for them to marry or to stay in a marriage will increasingly be more emotional than economic. It is likely that less stigma will be attached to differences such as single parenting, divorce, and choice of sexual partners. Bisexuality, homosexuality, and the new biotechnology of reproduction, including test-tube babies, artificial insemination and surrogate mothers will further challenge our understanding of ourselves as sexual beings and family members.

Clearly, our culture as a whole is in a period of dramatic and complex change in which our family structures, reproductive technology and sexual conduct are several steps ahead of our self-understanding, ethical values and decision-making skills.

educating our children about sexuality

Parents, teenagers and health professionals have all increasingly looked to the public schools for assistance in teaching young people about sexuality and family life. national Harris Poll found that 85% of adults support sexuality education in the public schools, a strong mandate for continuing to develop these programs. (Harris, 1985) The impetus behind much sex education has been the desire of parents and educators to reduce the numbers of teen pregnancies, to reduce the incidence of sexually transmitted diseases, and to counteract what many adults feel to be a growing sense of sexual freedom on the part of young people. Sex education specialists agree that their goals are broader, including helping both teens and adults develop a greater and more positive sense of their own sexuality.

"To recognize that human sexuality, along with the human body and the human mind, is one of the three elements most basic to being human, forces one to acknowledge how very far we are at this moment from treating it with the same acceptance and conscious nurture that have been accorded the two others. Sexuality remains one vital area of education that has been distorted and refused recognition by our sexually exploitive, poorly educated, overcompetitive and violent society. . . Building self-esteem about the goodness of all the child's endowments, including sex, and putting the child 'in charge' of its body and all its functions, including sexual pleasure, are vital steps in maturation." (Calderone, 1985)

While the majority of parents support sex education in the schools, a small but vocal minority continues to blame the problem of adolescent pregnancy on sex education.

One opponent wrote recently: "with the advent of sex education. . . .teen pregnancy in America has skyrocketed to epidemic proportions, at the very least it should be apparent that sex education in our public schools has failed to act as a sufficient deterrent to the 'sexual holocaust'." (Wyman, 1985) But sex education has not yet been widely available in public schools, and there is not evidence that sexuality education results in earlier or increased sexual activity among teens. In fact, research suggests that those who do not have sex education are more likely to begin early sexual activity. (Flick, 1986)

A complete picture of how many students actually receive sexuality education in schools or community programs is unknown. Studies suggest that between 10% and 55% of school systems in the United States offer some kind of curriculum. (Moore & Burt, 1982) But even when offered, it is estimated that fewer than one-half of all students to whom it is available actually enroll in the courses. Even then, the programs vary widely, most lasting less than 10 hours, and fewer than 40% include contraceptive information. Many programs do not involve parents — a component of sexuality education found to be very effective. Where parents are the main source of sex education and communication, their involvement results in delayed sexual intercourse among teens and increased use of contraception when intercourse does occur. In Maine, this inconsistent availability of comprehensive health education led to the adoption of new rules and regulations as part of the Education Reform Act of 1984. These changes require all school districts to offer comprehensive health education, including sexuality and famiy life education, for grades K-12 by August of 1986. Prior to this, the decision to offer such a program was left to the local school.

Many adults are concerned that sexuality education will encourage early sexual activity. Research indicates that teenagers who have had sexuality education are no more or less likely to be sexually active. In fact, there is "overwhelming support for the claim that the decision to engage in sexual activity is not influenced by whether or not teenagers have had sex education." (Zelnik & Kim, 1982) Other research indicates that teenagers who have not had sexuality education are more likely to begin sexual activity earlier. (Flick, 1986) Young women who have had sexuality education which includes instruction about contraception are more likely to use contraception when they begin to have intercourse, and show lower pregnancy rates than those who have not had this education. Finally, since teenagers have begun to have sexual relations at earlier ages in countries with little or no sexuality education, these changes in age of first intercourse appear to be due to broader societal changes and not due to introducing sexuality education in the schools. (Boethieus, 1985)

While formal sexuality education in the schools has been a piecemeal effort reaching only a portion of students, informal sex education reaches all young people through three main sources: the family, the media and peers. The ways love and affection are expressed in the family, as well as the verbal and nonverbal messages conveyed about body image, gender and social roles, and intimacy combine to make a child's home the primary source of sexuality education. Even when parents don't talk about sex, messages are conveyed. Most parents feel that they need help in talking about sexuality with their children and teenagers. They may have had no formal education in this area themselves, and so lack factual information. Many adults are uncomfortable about their own sexuality so find it difficult to have a relaxed discussion with their teens. Most teens express frustration with their parents' inability to communicate openly about sex. Young people are eager for help in understanding their sexuality, finding loving relationships, developing values, setting limits and establishing goals for their futures. When teenagers cannot get straight answers from their parents or teachers or other adults, they most often look to their peers for information, and what they frequently find is misinformation and confusion.

The media — television, advertising, music, videos, films — bombard children and teenagers with sexual messages. Sex is used to sell everything from toothpaste to automobiles. The average U.S. child watches more than 20,000 television commercials a year, most of which glamorize sex to sell their products. (Kale, 1979) "What's amazing is what you can get away with now," according to one New York advertising executive. "And over the next five years there will be an even greater use of blatant sex in advertising, because it's become a part of our culture." (Trachtenberg, 1986) Teenagers today are more pressured by sex around them than at any other time in our history. (Donahue, 1986) Much of the programming on television also emphasizes sex as "an overwhelming, uncontrollable, physical attraction and desire" without dealing with consequences. (Strouse & Fabes, 1985) Almost nothing they see or hear about sex informs them about contraception or the importance of avoiding pregnancy. In one year of average viewing, a teenager sees at least 9,000 scenes involving sex, according to the Women's Media Project of the NOW Legal Defense and Education Fund. A survey of what some of these scenes depict reveals that of all the "alleged incidences of sexual intercourse on television soap operas, 49% involved lovers, 29% involved strangers, and only 6% involved marital partners; and marital infidelity is presented as the major family problem." (Strouse & Fables, 1985) In none of these incidences is there any indication that either party is using contraception. In addition, the trend of movie and rock stars bearing their "love children" without marriage is well publicized in the media. Yet in spite of the frequent portrayal on television of sexual relations which are recreational and exploitive of women, the networks last year refused to broadcast a public service announcement (P.S.A.) proposed by the American College of Obstetricians and Gynecologists on the subject of contraceptive use. One network executive cited among the reasons for this decision "the question of taste as to the appropriateness of the broadcast of this sensitive topic when one is invited into the home." (Schneider, 1985) Other media executives stated that they had concerns about the Fairness Doctrine which would require that equal time be given to opposing views. While they felt they could not air the P.S.A., they offered to work with the physicians to try to resolve such legal issues. Later, with some changes, the ads were shown.

Within a context of misinformation, mixed messages, and unclear values teenagers must try to understand their sexuality and make important decisions about their sexual behavior. They clearly need help in evaluating media messages, acquiring accurate information, and weighing their own and their family's values against those presented in the media and elsewhere. Parents, schools, religious and community organizations can play a meaningful role in sexuality education as teens engage in these tasks.

goals and content

Sexuality and family life education (FLE) are defined in a model curriculum compiled by a 1982 FLE Interagency Work Group and approved by the Maine Department of Educational and Cultural Services as a "dialogue with individuals about who they are and how they relate to others." (Bignell, 1980) The aim is to help each individual understand himself or herself as a sexual being in a total sense and to use that knowledge responsibly. Generally it is agreed that children should have a sound understanding of the biology of reproduction and physical changes of puberty by the time they reach junior high school, so that as adolescents they can focus on values, decision making and relationships. (Schulz & Williams, 1969) While many teens lack basic factual information, sexuality education must involve more than factual content. The FLE Work Group identified three components to the curriculum:

1. Adequate and accurate knowledge of human sexuality in its physical, psychological and social dimensions;
2. Clarification of attitudes and values pertaining to sexuality;
3. Skills in decision making and communication.

While the teaching of a particular set of values is not appropriate for school sex educators, as one educator has pointed out "a sex education without values is valueless." (Gordon, 1984) He indicates that there is a difference between being moral and being moralistic, and that teachers can promote the development of values without proselytizing their own individual values. But knowledge alone is not adequate for many teens to act responsibly because they do not yet have the cognitive, or decision making skills to think clearly about the future consequences of their immediate actions. They need help in developing decision-making skills in the area of sexuality, as well as other areas of their lives. These skills can help teens to use the knowledge they acquire in making better decisions.

As a result of funding developed by the Work Group, a statewide Teacher Training Project to train teachers and help schools implement FLE curriculum was established in 1983. They developed nine concepts which form the basis of a responsible family life and sexuality education program and serve as useful guidelines in the development and implementation of programs. (Bignell, 1980)

1. Seek to maximize the involvement of students. Students are valuable resources and should be included in the planning of any programs intended to meet their needs. In addition, their active involvement in classroom dicsussion and activities is essential.
2. Involve parents and community members in the planning and implementation of curriculum.
3. Promote respect for parental values and encourage communication between students and their parents.
4. Reflect the diversity of values which exist in our pluralistic society, and promote a healthy respect for these differences.
5. Reflect sexuality as an integral part of the whole person, and promote positive and fulfilling sexuality as central to good physical and mental health.
6. Avoid crisis-oriented or fear tactics which may provide a great deal of anxiety, particularly in low self-esteem students, and make them less receptive to the intended message. (Leaventhal, 1971) Sex education is but one component of a successful program to combat teen pregnancy and its goals are more comprehensive than this single issue.
7. Emphasize respect for self and others as the fundamental basis for decision-making.
8. Promote a genuine dialogue based on accurate information where differences of opinion exist regarding an issue of sexual or reproductive health. In no instance should a teacher attempt to provide definitive answers or to represent his or her own view as the consensus of major religions or of our pluralistic society. (National Council of Churches, etc., 1968)
9. Establish an environment that encourages exchange of information and ideas. Students need to discuss their concerns, interests and ideas with peers in order to be clear about their own feelings and values.

parent, community and clergy roles

Because of strongly held individual values and differing community standards, parent support and involvement is an essential component of any sex education program in the school. Parents most frequently serve on advisory groups or on controversial issues committees, which help parents understand what is being taught and who is going to teach it. These groups also give parents an opportunity to discuss their concerns, such as the teacher's qualifications. Among some concerns are those voiced by parents in opposition to sexuality education in the school: (1) the teacher's attitudes regarding parents and parental authority; (2) the teacher's approach to values and morals particularly in the areas of homosexuality, masturbation, birth control and abortion; and (3) the general concern that the class will put ideas into their son/daughter's head. Parental involvement provides an opportunity for these concerns and questions to be answered.

Another way that parents can become involved in their children's sex education is through a parent companion course, which is an educational program offered to parents covering the major subjects which their children will be studying. It may include viewing films, books and other materials that will be utilized in the course which their children will attend. Communication skills between parent and child are an important aspect of parent companion courses, as well as the course for students, since they enable parents and kids to discuss sex more comfortably and to make their ideas and values clear to each other. These programs may include parent-child homework assignments which can encourage communication at home and begin to let the child know he/she has an askable parent. It is not important for parents to have all the answers to their children's questions about sex. What is important is that parents can talk openly with their children about sexual matters. Teenagers who have good communication with their parents, no matter what the content of the communication, are more likely to delay sexual activity. (Ooms, 1984)

Other community and youth groups can similarly play a meaningful role in sexuality and family life education. Children and teenagers need a variety of sources of information, as well as significant adults in addition to their parents, who are willing to genuinely listen to their concerns and help them develop decision-making skills.

The Task Force felt that the clergy and religious organizations had a very important role to play in this area. Schools and community groups can also help teenagers understand the diversity of values about sexual behavior and family life; can help students to clarify their own personal values; and can offer some general ethical principles, such as, that psychological pressures to be sexually active is as much a violation of another's rights as the use of physical force. But schools cannot teach a particular set of values or a moral code. Religious organizations can play a meaningful role in conveying the specific values which they believe should guide the people in their congregation. Religious organizations can help youth develop values consistent with their faith, and can place decisions about sexuality and relationships within a larger moral framework.

teacher training and selection

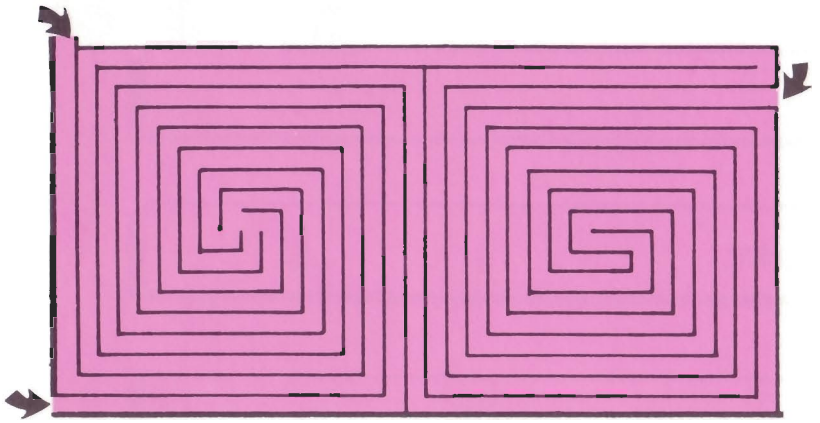
Sexuality and family life education taught in a school, community group or religious organization all require trained and competent teachers if students are to have a meaningful learning experience. Teachers need to be trained specifically in family life education, including understanding and feeling positive about their own sexuality in order to be comfortable dealing with this subject in the classroom. The Teacher Training project designed to provide family life education to teachers, school administrators, parents, clergy and other community members has been replaced with a FLE Curriculum Consultant on staff at the Department of Educational and Cultural Services. While staff is very limited for teacher training (from two trainers in 1985-86 to one trainer in 1986-87), progress has been made in strengthening the capabilities of local school districts to implement or improve the family life curriculum. (See Idea Bank for information on the Teacher Training Project.)

Present certification laws allow inadequately prepared teachers to teach health education. New rules and regulations for comprehensive health education

require instruction in ten content areas, including family life education. Other areas required in the curriculum include community health, consumer health, environmental health, nutrition, personal health including mental and emotional health, prevention and control of disease, accident prevention, and substance use and abuse including the effects of alcohol, stimulants and narcotics on the human system. This range of content areas make adequate preparation more important than ever. Efforts are under way, with leadership from the Maine School Health Education Coalition, to change the current certification requirements with these needs in mind. Of all the topics in a comprehensive health education curriculum, sexuality and family life education are the ones requiring the most skill and comfort.

Selection of teachers for sexuality and family life education must involve not only specific training, but also awareness of one's own values and attitudes, the ability to respect differing values of others, and the ability to foster classroom discussion so that ideas can be freely exchanged in a non-judgmental manner among members of both sexes. Support from school administration, other teachers and the community is vital. Teachers therefore may need others to work with them as advocates for the FLE curriculum, helping the community understand its importance, and encouraging local involvement in developing program content.

the system: finding a way through the maze



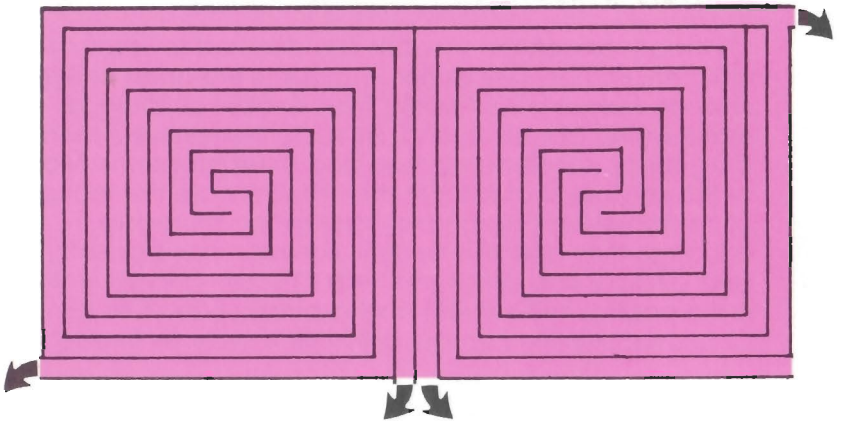
Today we have a complex system of health and social services available to teens with their families. It has developed in an effort to meet the needs of families which historically was provided by an informal network of family members, friends and neighbors. The natural helping network has been eroded over the years by a highly mobile population and a dramatic change in family structure. Additionally, in an age of specialization there is a tendency to rely on professional assistance for help with personal and social problems.

Pregnant and parenting teenagers are in need of many types of assistance. Sometimes help can come from family and friends, but in many cases the family is unable to provide critical support and assistance. Many teenagers who become parents live in families with severe problems such as alcoholism, spouse abuse, child abuse, sexual abuse, and chronic unemployment. For example, a Portland based teen parent program served 100 pregnant teens during one year; 97% of those teens reported that they had been victims of sexual abuse and other child abuse perpetrated by members of their family. (They represent approximately one quarter of the teens who gave birth in Portland during the year.) For these teens who will not be able to receive proper support and guidance from their families, an array of outside services and supports is necessary.

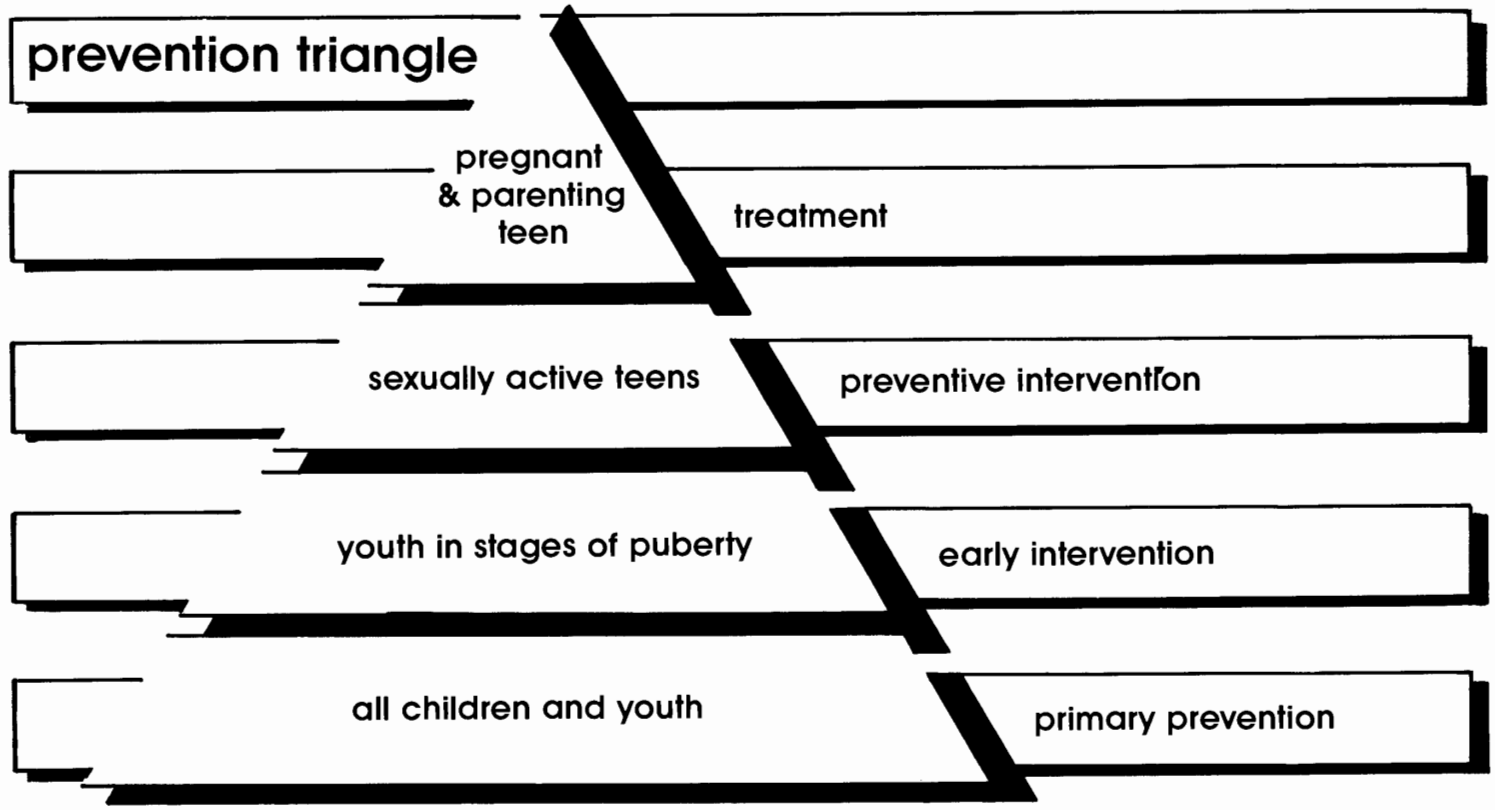
The service system for teens, teen parents and their families is at times cumbersome and confusing. It is complicated by the diversity of services generally required by the teen population. Rather than a unified organization, it is a complex group of services that has limited working relationships with or accountability to one another. The services involve different disciplines such as physicians, social workers, clergy and others in both the public and private sector.

An additional problem is that there is not one single easily identified target population for the prevention of adolescent pregnancy. Other service systems have a specific and identifiable client group. For example, nursing homes direct services to geriatric patients or people with long term health care needs. The W.I.C. program directs services towards mothers and children with nutritional needs. The Family Planning clinics provide education, counseling and contraceptive services for sexually active teens. Yet the services which have an impact on the prevention of pregnancy are diverse. They must encompass virtually all children and youth as the target population before sexual activity, during decision making stages, and once a teen becomes sexually active, pregnant and a parent.

In order to provide clarity to the service system framework it is important to define prevention. Definitions are often arbitrary and the strategies are not new. We use the "Prevention Triangle" which examines the service system in terms of the stages of decision making that children and teens experience regarding their sexuality and their level of sexual activity. The four categories of services described here are: primary prevention, early intervention, preventive intervention, and treatment.



the prevention triangle



primary prevention

Primary prevention services are directed towards all children. Primary prevention programs enhance children's skills and sense of self-worth. They enable children to make better decisions and, as such, they prevent teen pregnancy, substance abuse and other problems. Many of the services that fall into this category are not thought of as adolescent pregnancy prevention programs, although they offer this benefit. For example, boy scouting and girl scouting programs help children and youth to build positive self esteem and aspirations for their future. Churches provide primary prevention services through the programs teaching values clarification, moral support and decision making. Health systems provide primary prevention services by teaching children to understand, respect and care for their bodies. The educational system and community programs build basic career and job aspirations as well as provide education on family life, sexuality and health. Primary prevention activities are the least understood of all services partly because the clients do not have an identifiable problem. Thus, the programs are often not viewed as a vital service, particularly at budget or planning time. Parents need a clear idea of the

importance of supporting these services in their communities and of assuring that their children are involved in primary prevention activities.

An important consideration to the stages of prevention and intervention is the cost. Prevention services are often less expensive when compared with the high cost of programs to assist pregnant and parenting teens. As we move up the "prevention triangle" the financial costs to the community increase and the personal costs to the teenager skyrocket.

early intervention

The next level of the service system, identified as early intervention directs services toward youth who are approaching puberty. These youth are considered to be at-risk because they are at an age where they might choose to be sexually active and therefore place themselves at-risk of becoming pregnant. Family life education courses, community sponsored sexuality education, sexuality information from the family physician and career exploration programs are examples of early intervention programs that serve the whole at-risk age group. Some youth in this age group are at greater risk than others. Families who are experiencing sexual abuse, alcohol or drug dependency or domestic violence have a particularly high rate of teen parenthood. Some early intervention programs specifically target these high risk youth and provide services that increase their contact with the healthy adult world and provide opportunities for success. Examples of programs that target high risk youth are the Big Brother/Big Sister programs, Foster Grandparents and Upward Bound. With each step upwards in the 'prevention triangle' the risk of problems increase and the degree of required intervention is compounded.

preventive intervention

A third level of services are preventive intervention services. These services are specifically directed toward the sexually active teen. Services specifically work to prevent unintended pregnancy. This may be approached by encouraging teens to delay sexual activity and/or by providing contraceptive services. Family Planning programs, private physicians, health clinics and education services as well as peer networks and counseling programs are examples of preventive intervention activities.

treatment

The last level of the "prevention triangle" is comprised of treatment services designed to meet the needs of the pregnant and parenting teen. Although these services provide critical life support to new teen families, they often are hard for the teen to locate and use. She needs a variety of services, (many of which are not available in Maine communities) at a time of great emotional turmoil for her. The goals of treatment programs are to reduce the adverse effects of teenage pregnancy and parenting, promote positive parenting and to encourage the prevention of subsequent unintended pregnancies. Treatment services include comprehensive teen parent programs, counseling, child care, parenting education, health care, training and economic support as well as adoption and abortion services for the teen who chooses not to be a parent. The treatment programs must continue to be a priority within the service system. These same programs also become preventive services for the next generation as they help assure children of teenage parents a more secure and healthy family.

the services

Within the entire service system and among all levels of prevention and treatment there are several major areas of service: health/medical services; financial support; direct social service including counseling and peer support; child care; employment and education; and housing. These services at all four levels of prevention and intervention are complex, but it is at the treatment stage that the complexities of the system create the greatest obstacles, appearing to the client to be a complex maze. The following description of the service areas are offered to provide the context from which recommendations are made.

health and medical services

The health and medical services are extremely important and yet often unavailable to teenagers and teen parents. Teenagers are the neglected patients. In fact, teenagers are reported to be the least frequently seen age group in all types of primary health care services. Unlike younger children, there are fewer incentives for regular medical care such as booster shots. Teenagers are often expected to know their own health needs and how to acquire health care. Yet, most teens have very little information about their bodies. They are often timid in discussing their needs and questions. This creates an obstacle between the teen and the health care provider. The health and medical community, both as professionals and as adults, must take the responsibility to assist teens to overcome this barrier.

barriers to service

Many health and medical services are inaccessible to teens due to cost, availability, and location.

Financial barriers to quality health care are difficult to overcome. There are several financial assistance programs available to help defray medical expenses but they have complex eligibility standards and are often difficult for both the service providers and the patients to negotiate. Although a new child in any family causes increased financial demands, the most severe financial problems are not associated with the teen parent from the higher income family who has access to family resources. The family's health insurance may be of assistance in covering medical expenses. However, not all policies automatically cover the pregnant teenager in the maternity clause. Maternity coverage is often a separate rider which needs to be purchased before conception. New insurance would have to be purchased immediately after the delivery and the brief hospital stay because insurance companies do not maintain coverage for three generations under one policy.

Families who are living below the poverty line and are eligible for medical assistance will experience no financial barriers to health care because the costs are fully covered by the Medicaid program. People using Medicaid will experience the difficulties of complex regulations, applications and finding a provider who accepts Medicaid clients. The most difficult financial barriers are evident for the working poor family who is not eligible for medical assistance and yet has no insurance. These families, in order to avoid costly medical bills may need to have their teen daughter move from the family home in order for her to receive the needed medical assistance.

The following hypothetical case is presented to explain the complex medical assistance programs and the effect on families. Consider the needs of a mother who is the single head of household with two children, one of whom is a pregnant teenager. She earns $5.77 hourly which is a gross income of approximately $1,000 per month. She is looking for assistance in paying for the pre-natal and delivery fees for her daughter because she has no medical insurance. After you apply the various Medicaid formulas to her salary she will be $400 over the guideline for the month. Officially she is not eligible for Medicaid.

If she is persistent enough to continue her interview with Medicaid she will discover that there is another part of the program to assist her. It is called the spend-down program. The Medicaid eligibility worker will then apply some additional formulas to the $400 excess in her income and determine that after she spends $2,400 in a six month period on her daughter's medical expenses then medical assistance will be able to take over the remaining bills.

Most normal deliveries will be slightly under this expense so medical assistance has effectively not been of any help to her. However, the Department of Human Services is aware of this problem and has attempted to respond by creating the Maternal and Child Health Prenatal Care Program. Hopefully this family was referred to the program immediately because if service is not requested in the first two trimesters of the pregnancy, service will be denied. If she requests help within the time frames she will be eligible for assistance for all pre- and post-natal doctors' bills, drugs, delivery costs and even the cost of an anesthesiologist.

The only remaining problem is the actual cost of the hospital. For a normal delivery this cost can be $1,000 and for a Cesarean section the cost can be over $3,000. These expenses are not covered by the Prenatal Care Program.

There is one more possibility for financial help for this family. After the baby is born they may apply again for medical assistance. This time they have one additional deduction because of the new household member. With these computations the family would now be required to spend only $200 before the spend-down program can be activated.The medical assistance program then has the option to pay for the hospital bill retroactively.

Obviously this is a very complex program. After the formulas are used, every family will have a different eligibility experience. One thing all families who apply for this have in common is frustration and confusion while trying to obtain help.

It is clear that some families will fall between the cracks of the system. They do not receive help because they do not proceed to the end of the process or they are told that they are ineligible, which discourages them from applying again.

Availability is one other barrier to service. There are not enough health and medical practitioners who are trained and committed to work with the teenage population. Teenagers have outgrown the services of the typical pediatrician's office. They often find that when they look for help they can not find a health professional who is responsive to their needs. This is compounded by the fact that the few available teen oriented services are not well distributed throughout the state.

Location of services is the third major barrier. This relates to poor geographic distribution but it also refers to transportation problems of teens. Throughout Maine, public transportation is largely unavailable. Teens need to rely on family, friends or public service workers for their transportation needs. In many cases the teen will simply not utilize services because no one is available to transport them.

school based health clinic

A new approach to overcome barriers for teens and to make primary health care available is the school based health clinic model which locates services in or adjacent to the school. It generally provides primary health care as well as education and health information. The model requires parental permission for teens to use the health services and seeks to encourage parental involvement in the program. The school based health clinic is intended to meet the needs in each community as designed and developed by that community. Some communities choose to provide only primary health care while others include reproductive health care. As a part of reproductive health care some communities have chosen to also provide contraceptive services. Funding for school based health clinics comes from a variety of community and governmental sources, and is not intended to be part of the school budget. This model of service provision overcomes many of the specific barriers to teens by making the services readily available, with an appropriate location and no financial burden to the teen.

Planning for two school-based clinics is under way now in Maine: one for Portland and one for Bonney Eagle High School in West Buxton. While these clinics have raised some controversy, studies from clinics in St. Paul, Minnesota and Baltimore, Maryland and elsewhere have yielded some very hopeful results. In schools participating there has been a significant decline in the teenage birthrate: in St. Paul from 59 per 1000 in 1976 to 26 per 1000 in 1984.

These programs also helped young mothers to stay in school after delivery, and repeat pregnancies were much lower than among pregnant teens who left school. Studies from the Baltimore clinic found that teenagers were less likely to get pregnant, more likely to use birth control, and more likely to delay first sexual intercourse after the program began. The program included having a nurse and social worker offering education in the classroom, both junior and senior high, during the mornings. Lunch hours offered individual and couple counseling, and in the afternoon, the staff was available in a clinic on the same school block, where teenagers were encouraged to come for counseling or medical contraceptive services. After two years, the rate of pregnancy decreased by 30% among girls in the program. Both boys and girls are more likely to seek birth control before their first sexual intercourse. At a similar clinic in St. Louis, sexual activity remained the same after the clinic began operation with 70% of high school students saying they had had intercourse. In Baltimore, the median age for girls becoming sexually active was 15 years 7 months before the school-based program, and 16 years 2 months after the program. This strategy offers a hopeful new direction for slowing down teenage pregnancy and for assisting teenage parents who remain in school.

family planning

The Family Planning clinic system is another service that works to overcome the barriers for teens by choosing appropriate locations, offering trained personnel, and confidentiality and by providing low cost or free services. The Family Planning programs provide teens with primary health care and specific reproductive services, including contraceptive care. Family Planning also provides educational programs for the public to increase knowledge of the positive aspects of sexuality and reproductive health. Recent data from Johns Hopkins University indicates that informed teens tend to make more responsible decisions and also tend to delay sexual activity. Family Planning clinics are located in independent offices, at rural health centers and as part of larger organizations. The Family Planning clinics in Maine see approximately 11,000 teen women each year, 90% of whom are sexually active. National data combined with Maine estimates indicate that there may be approximately 21,000 sexually active teen females in Maine.

Local drug stores are another source for contraceptives. Buying contraceptives over the counter may be sufficient for some teens; however, it does not provide a professional person with whom to explore options, clarify decisions and review total health needs.

Teen males generally do not use the services of family planning. They perceive the services to be "just for females." Family Planning is able to serve males but can not provide adequate outreach to promote the importance of reproductive health care for males. This type of outreach would require considerable staff training and increased funding.

pregnancy testing and options counseling

The ideal service for a teenager who suspects she is pregnant would be non-directive pregnancy options counseling which offers factual information about all options, emotional support, a focus on how the teenager feels about herself, as well as referral to other appropriate services (such as prenatal care, adoption agency or abortion facility). Very few pregnant teenagers receive such comprehensive counseling when they become pregnant.

Teenagers who rely on drugstore pregnancy tests receive no counseling, information or referral with their test results. Those who visit a local physician may also receive only test results, although some physicians will only give out the results with counseling. Several private agencies in Maine offer non-directive comprehensive options counseling. These include the Good Samaritan Agency and the Maine Children's Home.

Birthline, a program of Diocesan Human Relations Services, offers pregnancy testing, counseling and support services, as well as information and referral. Their services do not include information or referrals for abortion. The Family Planning clinic system in Maine offers pregnancy testing and options counseling which includes referrals for abortion, adoption and prenatal care.

The Task Force heard of a growing concern among health professionals, guidance counselors and teenagers

about other privately operated community pregnancy centers which offer free walk-in pregnancy testing. The facilities have developed in the past two years in Portland and several other Maine cities. Such centers are listed in the yellow pages under "family planning services," "clinics," "birth control information," and "pregnancy information services." Their advertisements state that they provide "abortion information," but in reality they provide anti-abortion information often based on scare tactics, harassment and dramatic media presentations. The centers are part of a national anti-abortion strategy and frequently are located near family planning clinics. Unfortunately some teenagers may unknowingly use the facilities since their pregnancy testing is free and their advertisements suggest that comprehensive counseling is provided. The centers' scare tactics do little to help an already frightened teenager to make decisions based on her needs and values.

Finding an appropriate resource for pregnancy testing, emotional support and comprehensive non-directive options counseling is a major obstacle for many teenagers since they are often naive about the health care system and embarrassed or frightened by their pregnancy.

maternity care

The pregnant and parenting teen has health and medical needs for pre- and post-natal care for herself and for pediatric care for her infant. Pregnant teens report feeling uncomfortable and judged at the office of the general practitioner or the obstetrician or gynecologist. Those services are designed for married adults and leave the teenager feeling inadequately served. Some teen parents neglect the health care needs of their children because of their own negative prenatal experience with health/medical services.

The public and community health nursing programs are available to teens for pre-natal care and for information and health screening for infants. These services are provided in the familiar environment of the teen's home and so overcomes some barriers to service. Teens are not likely to request this service for themselves. This fact makes service delivery dependent on referrals from other service providers who interact with pregnant and parenting teens.

abortion services

The teen seeking abortion will discover that there are few medical practitioners available for abortion services. It is not uncommon for a patient to travel over 75 miles to get to the service provider. Referral information to the various abortion services is also not readily available. Abortions currently cost between $250 and $550 depending on the services needed. This cost is covered by private insurance but is not reimbursable by Medicaid. The teen without private insurance or who is on Medicaid will have to find a way to pay for the service by herself. This creates a real obstacle for teens with limited financial resources because of the limited amount of time between the determination of a pregnancy and the point at which the abortion needs to take place.

financial support

AFDC (aid to families with dependent children)

Most teen parents are not equipped to financially support themselves and their child because of age and lack of work experience. Therefore a cornerstone of their social services must be financial assistance which provides them with a minimal cash income. The AFDC program is the major source for financial assistance. It is estimated that approximately 1,000 teen parents use this service each year. (Projections indicate that Maine has as many as 4,000 teen parents at any given time.) The AFDC monthly cash grant assists teen parents in purchasing housing, food, transportation, clothing, household supplies, children's goods and other basic needs. The program is well known and the locations of the AFDC offices are distributed throughout the State.

There are three problems which complicate the delivery of this service. The first is that the clients report humiliation and discouragement when asking for AFDC assistance. It is often the first public service that a teen parent approaches. A negative experience is likely to create distrust and reluctancy on the part of the teen. She may avoid public assistance and, without other appropriate means of obtaining help, may ultimately deprive herself and her child of basic needs.

The second problem is that information about and referral to other services are not adequately provided to the AFDC recipient. This fact makes it difficult for teens to obtain services and to understand which of the many organizations is providing asssistance. A good example of this is a young teen mother who declares, "I am on-the-state but all they give me is coupons for milk and cheese." This mother is actually a client of the W.I.C. (Women, Infant and Children, a supplemental food program). She may not realize that there are other services available to help her provide food for her family such as the State sponsored Food Stamp program or a local food bank. A person in need is not in a position to have an overview of the available services. Teen parents have minimal skills to advocate for themselves. Many of the workers in these direct service programs are aware of these problems and work to prevent the confusion of the client. However, the workers are handicapped by lack of training and limited access to resource information as well as by large case loads that prohibit personalized attention.

The third major problem with the AFDC program is simply that the monthly cash grants are too low. Combined with all other available benefits it does not even provide resources to bring the family income to the poverty line. The poverty line is the income level set by the Federal government which approximates the amount of money that will allow a frugal family to barely pay for its most essential needs. A teen parent in Maine with one child will receive $289 each month. She is young, alone, receives no child support, has no child care and no job skills. Rents range from $200 per month in rural areas to $500 per month in the larger cities and towns. The AFDC check for most teens will not even cover their rent expense and leaves no money to help with clothing, transportation, recreation or other living expenses. In addition to the humiliation of applying for AFDC and the lack of information about other services, the teen parent experiences the frustration of being unable to meet basic financial needs.

child support

In a single parent home economic support may be provided by the absent parent through "child support," often established in a support order through court action. For the single teen parent, several obstacles to child support must be overcome including establishing the father's identity. Paternity is most frequently determined when the father is legally named on the birth certificate. However, the younger the teen, the more likely that the father will be listed as "unknown" on the birth certificate.

When the mother applies for AFDC, she must name the father in order to be eligible for benefits. The Division of Support Enforcement which administers the Support Enforcement Location Unit is the primary state agency responsible for locating fathers, proving paternity and moving for support orders. Any parent can enlist the assistance of the SELU, not just AFDC clients. Paternity may be established up to the child's 18th birthday and in some cases as much as six years beyond. The Support Enforcement Location Unit will contact the father and offer him the opportunity to acknowledge paternity and hold an administrative hearing to determine his support payment. If he contests paternity, the case is turned over to the State Attorney General's office where court action is initiated. He is given one of several highly accurate blood tests. If the test is positive, usually he will acknowledge being the father. (Although he is still entitled to a jury trial.) His name will be placed on the birth certificate and child support payments will be established. He may be ordered to pay other expenses such as medical costs for birth, medical expenses for the child, and back child support.

The AFDC program will not deny benefits if the father is honestly unknown, if he is deemed dangerous to the well-being of mother and child, or if the pregnancy was a result of rape or incest. If the mother simply refuses to name the father the AFDC program may arrange for "protective payments" for just the child, usually through a third party such as a grandparent.

Maine's child support program is an aggressive one built on the incentive to break the ever-increasing cycle of poverty for thousands of Maine children. It has been

successful in increasing collections to the degree that has elevated Maine's program to 2nd in the nation. But the success of this program and the aggressiveness with which it seeks to establish the father's identity and economic support for the child, does not apply to teenage fathers. There are several problems. The teen mother's reluctance to name the father, either to protect him or out of shame and embarrassment, prohibits the establishment of paternity. Maine's child support enforcement officers are "bill collectors" not social workers trained to work with teen fathers who themselves require special attention as minors.

And lastly, the teen father's minimal support payment — the result of unemployment, in-school status and no income — makes his collection lowest priority. This is complicated by the "incentive" nature of the enforcement agency's federal funding: the greater the amount of money collected, the more money that becomes available to staff the programs. It is an unfortunate cycle which creates an obstacle for locating the hard-to-reach teens.

In Wisconsin a "Grandparents Liability" law was enacted in 1985. It makes the parents of teenage mothers and fathers financially responsible for their children's children. Nonsupport of these youngsters by grandparents until the teenagers turn 18, whether they are married or not, could lead to prison terms of up to two years and maximum fines of $10,000. Thus far, the program is not working as planned. One of several problems is that often by the time paternity is established (a lengthy process of one year or more) most teenage fathers have turned eighteen and are no longer legally in their parents' care. Nine months after the law was passed there was only one case of grandparent liability pending.

Just as the desired side effect of the Wisconsin Act 56 is to compel parents to educate their children about sexual behavior, pregnancy and their responsibilities, Maine's program for teenagers should strive to teach responsibility to the young fathers. Granted their payment would be small, but the experience of learning about the needs and rights of their children would better prepare them to be responsible when they reach adulthood.

general assistance

Another source of financial assistance is the city or town welfare office. All towns or cities in Maine have a welfare office or an "overseer-of-the-poor" which offers general assistance in the form of small cash grants. Larger towns have specific programs and a standardized process for applying for general assistance or emergency aid as well as linkages with other resources in their community. The quality of the services in the small towns depends entirely on the person who is assigned to administer the program; often it is one of the elected town officers. General assistance can be crucial in providing needed help but is also one more service provider to learn about and to locate.

food assistance

Another form of financial assistance is the state Food Stamp program. Eligibility can usually be established at the same time and place as AFDC eligibility, although they are administered as different programs. The program has some of the same problems as the AFDC program but clients do not report the same frustration. The biggest problem is that the Food Stamp allotment is usually not large enough to last the entire month. The teen parent has few other places to turn for assistance. Some towns have food banks provided by churches and volunteer organizations. The teen faces poor nutrition due to a lack of money for food and minimal understanding of food values and menu planning. The W.I.C. program provides vouchers for specific high quality foods such as cheese, milk and some cereals as well as providing education about nutrition. W.I.C. serves pregnant and nursing women, infants and children who are in nutritional and financial need.

social services

There are a wide variety of services that fall under the heading of social services. Of primary importance to pregnant and parenting teens are: teen parent programs, peer networks, counseling services, adoption services, and case management and advocacy assistance. Most of these services are provided by private agencies in the community funded through a combination of state or federal block grant dollars, private and municipal resources.

teen parent programs

Teen parent programs provide a broad range of specialized intervention services that include emotional support groups, therapy groups, parenting classes, birth preparation, tutorial and educational programs, and a general advocacy service. They help to support healthy children and parents, build healthy peer relationships among pregnant and parenting teens, and promote good parenting skills. There are not enough comprehensive teen parent programs distributed throughout the State. And there are often waiting lists to participate in the programs. The Portland YWCA Teen parent program provides comprehensive services and includes program development and networking with other providers.

peer networks

There are peer support networks throughout the State sponsored through public high schools and community organizations. The Peer Intervention program at the Auburn YWCA uses state and local funds to develop a network of peer support programs statewide. One of the advantages about peer programs is that they can be organized around any topic or concern. Some peer groups meet to provide counseling support to one another while others work on projects such as Project Graduation, Teens 'N' Theater, and Students Concerned About Bias in Society (SCABS), and Quest (Questioning, understanding, empathy for students). The peer network creates an opportunity for teens to productively use their influence to effect their own lives and the lives of other teenagers. This is particularly helpful for teen parents; peer programs can help them learn to be good parents.

surrogates and adult role models

Many teens, whether pregnant, parenting or not, are in need of an adult to offer direct personal support and guidance when it is not available in their family home. A teen parent may need someone to instruct her in basic infant care and feeding, help her shop for groceries that are nutritious and economical, provide her with transportation to the doctor's office and, generally, model healthy parenting behavior. Although this need is basic and important, few programs are able to provide in-home visitation and assistance to teens.

Several agencies throughout the state offer homemaker and "parent aide" type services: The Diocesan Human Relations sponsors four programs statewide, Community Health and Counseling and Androscoggin Home Health, all hold contracts with the Department of Human Services to serve priority high-risk clients. Among these are teen parents who are open protective cases or clients of the Family Services Program.

Other teens may be offered home visiting services and assistance through local community health and social service agencies such as physicians' offices, teen parent programs, child day care or nursing programs.

One model being developed in Maine uses "community women" of various ages and backgrounds who are highly trained and skilled to provide emotional support, information and assistance to teens and teen parents. The program offers volunteer services but is designed to work closely with community agencies and has as its goal the prevention of pregnancy as well as promoting healthy parenting. This model is being developed by the Office of Children's Policy (DHS) and Washington County service providers. Another model is

parent volunteers who provide one-to-one support for new parents to prevent child abuse by offering information and support, increasing parents' self-confidence and helping them develop realistic expectations. The Hancock County Child Protection Council, Inc. has been pursuing the development of this program model. Other models of volunteer and one-to-one support include the Big Brothers/Big Sisters and the Foster Grandparents programs.

parenting education and communication skills training

Among the most critical problems teens face are conflicts and communication breakdowns with their parents. Often the sources of communication problems involve difficulties which teens and parents have in listening respectfully to each other and understanding the differences in values and opinions. Parenting education and communication skills programs are designed to improve parent/child communication and increase parents' knowledge and skills of childrearing. Support groups provide self-help and peer support activities which foster parenting skills. There are many different types of programs throughout Maine.

The Division of Maternal and Child Health conducts a public education effort to reach parents through television advertisements, public service announcements (PSA's), and a statewide toll free telephone line. Parents who call the Division receive educational and resource guides which provide names of local parenting programs. In addition, they receive a copy of "Maine Parent", a 15 page magazine developed by Maine health and education professionals.

Other sources of parenting education include workshops, clinics, and training sessions sponsored by the Family Planning Association of Maine, member agencies of the Statewide Service Providers' Coalition on Adolescent Pregnancy as well as the Regional and State Coalition, independent parenting professionals, the PACT programs (Parents and Adolescents in Changing Times) sponsored by rural health clinics, public and community health nursing programs, and other local parent resource centers. Most programs offer free or low cost fees for teens, teen parents and other eligible families.

counseling

Counseling programs that provide on-going therapeutic treatment are essential for pregnant and parenting teens. The counseling service system is complicated. There are many different types of providers including clergy, social workers and psychiatrists. In addition, certain counseling professionals offer specialized services for specific problems. A teen client has very little knowledge of what type of counseling service she needs and is intimidated by jargon and professionalism. Mental health counseling centers receive state, federal and private funds to provide low cost services to their clients but they have long waiting lists and complex eligibility guidelines. The services are often not available to meet the crisis oriented needs of the teen client, especially the pregnant teen.

adoption

Only a small number of pregnant teengers choose adoption for their children. We do not know of the exact number because of the various private and independent adoptions. Based on both national projections and available Maine data, there are, at the most, 80 teens who choose adoption for their children annually. Many people feel that there is a social stigma attached to choosing adoption. The last twenty years, which has shown an increase in the rate of single adult heads of household, has created role models for the single teen parent. It is no longer shameful to be a single parent. In fact, the public opinion may have shifted to believing that it is wrong to have others raise your child. This makes it difficult for a teen parent to choose adoption, even if she thinks it is the option that is right for her and her child. The services of adoption agencies are not well known. There are several private adoption agencies in the state: St. Andre's (Biddeford), Maine Children's Home for Little Wanderers (Waterville), and Good Samaritan Agency (Bangor). Adoption services are also provided by the Maine Department of Human Services. It is difficult for a teen to determine where her needs would best be met.

These programs all provide services that are assured by state regulations and licensing procedures. It is still possible in Maine to utilize adoption processes by engaging in a private arrangement with a doctor, legal counsel and adoptive parents. These services are not regulated by the state and can, therefore, be subject to abuses and illegalities. An advocacy system for a teen wishing to explore the option of adoption for her child might be useful in helping the teen to approach this service system.

case management and advocacy

Teenagers trying to navigate the complex service system are in need of assistance and guidance of an adult. Most of the social service organizations that provide services to teens have case managers and advocates on their staff who link the teen with other services and opportunities in the community. One of the difficulties for the teen is the confusion of having different case managers at different agencies, as well as the lack of communication that sometimes exists among community agencies. The Statewide Service Providers' Coalition on Adolescent Pregnancy, which has a membership including most of these services in the state, mandates that the member agencies work to link teen parents with all other services. The State Department of Human Services operates the Family Services program which also works to assure that teen parents are receiving all the available services. The Family Services program assists AFDC teen mothers who volunteer to receive program services. They are assigned a case manager to assist on a one-to-one basis by providing guidance and advocacy. Most service providers find case management to be a beneficial service, although it is expensive to operate because of the individual attention required for each teen. It is generally felt that there are not enough case workers for teen parents at either public or private programs.

child care

Child care services for all single parents is absolutely critical. The teen parent has the added need to finish school, participate in training programs and seek employment. The lack of care for a teen parent's child often prevents the teen from accomplishing these tasks and locks the teen into a cycle of poverty. Quality child care programs provide the added benefit of assisting the parent in learning child development and appropriate discipline techniques. Finding a service that meets the need for flexibility, that she can both get to and afford are all major barriers in obtaining child care.

The 1985 Maine Child Care Report describes child care as an emerging crisis and acknowledges drastically inadequate numbers of child care providers. For a teen parent even a cost of $1.00 per hour is prohibitively expensive. The direct result is that children are often left without care or with inappropriate care givers.

The Headstart program and publicly funded daycare programs provide service for many low income children. However, there are vast waiting lists and stipulations which limit access. For example, the Head Start program operates only during the school year and it is not a full day program. Most child care programs do not serve infants. The infant care is extremely expensive to provide due to licensing standards which, for safety purposes, require a higher adult/infant ratio.

housing

Although some teens live with their families during the pregnancy and the early stages of parenting, many teen parents come from families with severe and chronic health or social problems. Many pregnant and parenting teens have a need for housing, such as emergency temporary housing, supervised living setting or an independent living unit. Finding appropriate housing, no matter which type of housing she needs, will be a problem.

The final two dilemmas for the teenager in the housing maze are: (1) some housing complexes will not allow teenagers under the age of 18 to sign contracts for the leases, and (2) the applications and search for housing require a high level of reading skills. For the teen with illiteracy problems this is an overwhelming obstacle.

employment and education

Employment and education are joined together in this section because of the central role they play in providing the teen with the possibility for a hopeful future. Teen parents have a responsibility to work in order to provide financially for themselves and their children. However, it is unrealistic to expect teenagers to be able to carry out this responsibility full time or to the exclusion of other adolescent activities. The teen parent also has the responsibility to continue education and to continue their normal adolescent growth. Education, job training and employment combined provide the tools for successful adulthood.

the public education system

The public education system has several ways to respond to pregnant teenagers. Special education funding enables school personnel to activate special resources to meet the needs of the pregnant student. This may include special class or in-home instruction and tutoring as well as alternate scheduling. According to preliminary data from a study by the Department of Educational and Cultural Services, approximately 49% of pregnant teenagers stay in their classrooms. This is a positive indication of the support and encouragement that those teens are receiving in order to complete their education. Approximately 1% have been expelled or suspended and 17% have dropped out of school.

Teen parents frequently report a lack of family support and an inability to find child care as reasons for dropping out of school. Without quality child care the teen will face obstacles in completing her education and it will continue to challenge her in all efforts to become self-sufficient.

cooperative education

Cooperative education programs, as well as internships and apprenticeships, are great benefits to parenting teens. These programs help the teen to bridge the gap between the adolescent world of the student and the adult world of the employee. These programs help prevent future unintended pregnancies and prevent chronic poverty in the life of a teen parent. However, in order to enroll in the public education cooperative education program, the teen needs to remain in school. Obviously other obstacles must be overcome in order for the teen parent to participate in this program.

weet program

The teen parent who is on AFDC is also eligible to participate in the WEET (Welfare Education, Employment, and Training) program. This program is mandatory for AFDC clients with children over six and those who live in certain accessible geographic locations. However, teen parents are eligible to participate even though their children are usually not over six. At this time very few do participate. WEET provides training and educational opportunities, as well as fully subsidized and partially subsidized employment. The goal for the client is to be able to eliminate her dependence on welfare. WEET also provides stipends to assist with child care and transportation. Many teen clients report that they have tried to participate in programs like WEET but that they are discouraged from applying because they are too young or should be at home with their children. This program, like so many others, suffers from complexity, regulations and the difficulty of making the service understood by the teens.

emergency housing

The teen that is forced to leave her family's home during the crisis of the new pregnancy must face the difficult task of finding housing at a time of great emotional upheaval. In some areas of the state this type of housing is available through private shelters which house runaways and other children in need. Examples are: Fair Harbor program and Little Brothers (Portland), New Beginnings (Lewiston) and Halcyon House (Hinkley). Although teenagers throughout the state are eligible to use the services of these programs, they generally do not know how to find the service. Another form of emergency housing is provided by the Department of Human Services Foster Care Program. This is available to teenagers under age 18, but they must participate in a process that makes the state their temporary guardian, and it can involve them in a complex court process with their parents. It is a cumbersome process that many teens say they do not want to experience. Some teens have had a negative experience with the foster care program or child protective service earlier in their lives and may not turn to the state system for help.

semi-independent housing

Many teen parents believe they are ready for the tasks of adulthood and parenthood on their own. Semi-independent living can offer teens a separate apartment within a larger building or complex that also has adult house-parents available to assist the teen. This is particularly helpful to teens who have never lived alone and who need to develop skills such as grocery shopping, infant care, assessing their child's health, or even skills like meal preparation. This program serves as a transitional living situation while the teen develops readiness for independence and parenthood. It could be available to married teens who also need support in the development of their marriage and co-parenting relationship. Unfortunately the semi-independent living model is scarcely available in Maine.

independent housing

Teens that are ready to live independently need to have housing available to them that they can afford. Maine has little affordable housing for teenagers. Although it is against the law in Maine to discriminate in housing based on a person's age or the number of children, it is actually a frequent occurrence for teen parents to be refused rental housing because of their age and because they have children.

With no job, no child support and only the AFDC check, the teen simply can not afford to pay the rent without additional financial support. General assistance funds may be available through town welfare to assist the teen. This help is often only temporary. It is also common for different towns to interpret the responsibilities and purposes of general assistance differently.

The Maine State Housing Authority has several methods for assisting with the housing needs of low income people. The two major options for service include: a subsidized housing complex or subsidized vouchers for rental payments. The Housing Authority is able to provide only 20,000 households with rental assistance through these and similar programs. Housing and Urban Development (HUD) and the Farmers Home Administration (FmHA) also participate in housing assistance programs. However there are an estimated 20,000 additional eligible households. At this time the waiting list for these programs is six months to two years long.

The application process, involving multiple applications for both the organization providing the financial assistance and the owner or manager that actually operates the housing complexes, creates an obstacle for the teen. In many towns there is not an office of the Housing Authority, so there is no one locally available for help.

The process of searching for an apartment is discouraging and confusing. As recently as ten years ago it was very common for social service organizations to assign a staff person to assist clients in finding suitable housing and options to pay for their housing. With restrained budgets for social services it is now difficult to find an advocate to help with this cumbersome process. The teen parent population is in desperate need of one-to-one support and advocacy.

training and referral

The final area of the service maze may actually be invisible to the teen parent. There are many issues relating to service delivery to teens that the professionals need to address. The Statewide Service Providers Coalition on Adolescent Pregnancy is one organization that works to provide training opportunities for other professionals, as well as the Family Planning Association of Maine. More training is needed on the needs of teens, such as communication and confidentiality as well as issues related to sexual abuse, alcohol and drug abuse and its relationship to early sexual activity. Values clarification training should also be provided to enable adults to understand the positive and developmental aspects of teen sexuality. Training should be provided by the experts in the field and must be advocated for by the professionals committed to working with teens.

Service professionals also need training in order to make more effective referrals. It may be enough to tell an adult that another service is needed and where to obtain that service. The adult may have the initiative and understanding of how to obtain help. The teen client, whether a parent or not, needs to have referrals made in a manner that assures that the teen will receive all the services needed. The providers must make linkages with one another to assure that someone is assisting the teen with service barriers. The Coalition on Adolescent Pregnancy has assisted with the first step in this process by networking, developing local resource directories and improving case management. The members of the service community should participate with and augment this effort.

summary

Teenagers are at an important crossroads in their lives. They must prepare to make decisions about their education, their career, their relationship with their partner, and where they will live. All of the decisions easily affect the quality of their lives. The pregnant and parenting teenager generally has little time to prepare for responsible decision making. Instead she finds herself in the middle of adult decisions which she must make quickly despite the time of stress. All of the service systems should have as their goal to remove barriers, and to avoid confusion and discouragement for the teen. But most importantly services need to help her secure for herself the best possible home, adequate health care and income sufficient to provide for her child.

building hopeful futures

self esteem

Most teenagers do not get pregnant. One of the main reasons is that they have hopes and plans for their futures which make early parenthood undesirable. For some teenagers, especially those lacking a sense of self-worth and future options, becoming a parent — even a single parent — is a way to feel respected and loved, a way to take on an adult role, a way to bring purpose and meaning into an otherwise directionless life. But these teenagers rarely anticipate the difficulty of being a parent and a teenager at the same time, and the further drop in self-esteem these demands can create. The Task Force worked with an assumption that a person with high self-esteem is likely to make better choices about life, including sexual activity, than a person with low self-esteem.

Self-esteem refers to how much one likes and respects one's self. It is a response to one's self-concept — the set of beliefs and images a person holds about him/herself which includes facts, roles, characteristics and attributes. One's self-concept might include such statements as: "I am a woman; I am tall; I am a mother; I am a lawyer; I am poor; I am sexy; I am unlovable; I am ugly." These beliefs are learned and some of them may be based on facts, while others may be how a person perceives her/himself. Self-esteem is learned, in part through the way a person is treated by others and the verbal messages received. If a child, for example, receives more negative feedback than positive, a negative belief system is learned. When children receive positive messages about being valuable, capable and loved, then self-esteem can grow.

Self-esteem is also determined by cultural factors. This has particular relevance for women and adolescents. For women growing up in a male-dominated culture, the message that they are less capable and valuable than males results in low self-esteem. A recent study of women and self-esteem asked women the question, "What do you like about yourself?" One in five women surveyed answered, "Nothing." The study suggests that this lack of self-esteem is linked to the view that men are seen as "inherently superior to women, and the traits associated with males (e.g., rationality, independence, leadership quality) are the ones this culture values most; whereas the traits commonly associated with females (e.g., emotionality, sensitivity, cooperativeness) are those this culture values least." (Sanford & Donovan, 1985) Of course these stereotypes about what it means to be male or female are limiting both genders, but women experience the most disability from them because they are taught to think of themselves in a narrowly defined way.

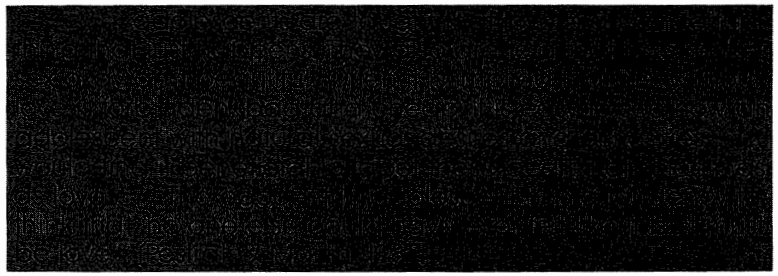
For adolescents, both male and female, there are problems of self-esteem brought on by the dramatic physical, emotional and social changes of puberty. Any major life change, good or bad, causes a drop in self-esteem. Adults may negatively judge teenagers' clothes, music and friends, without acknowledging their need for acceptance and connectedness with others. When teenagers are treated with distrust by adults, or portrayed in the media as destructive, wild and irresponsible, this does little to help them adjust to the changes they are experiencing. And the culture offers few opportunities for teenagers to test out their developing maturity in responsible roles, either in the school or the community. Considering these hurdles which the culture places in their way, it is impressive that most young people move through this period of their lives relatively smoothly, building friendships and more intimate relationships, and preparing for careers and independence.

But for adolescents with low self-esteem, low educational and occupational aspirations, and little sense of influence over their own futures, this process does not take place so smoothly. They tend either towards passive inaction (just "letting things happen"), or to making decisions which increase their risks of becoming teen parents. These adolescents tend to begin sexual activity earlier, to be less likely to use contraception, and to be less likely to have an abortion if an unplanned pregnancy occurs. (Flick, 1986) Other factors which both lower self-esteem and increase the risks of early sexual activity and the non-use of contraceptives include: poverty, lack of employment or future prospects, more traditional views of sex roles, poor communication skills, and having friends or family members who were adolescent parents. (Flick, 1986) These factors make it clear that preventing teenage

pregnancy is a challenge that begins well before the adolescent years, and extends beyond any one individual's responsibility. Building self-esteem and hopefulness in youth is a challenge to all social institutions that touch their lives — the family, schools, community, church and synagogue, health and social service programs. If the origins of the problem are both personal and cultural, so must be the solutions.

decision making

It is important to note that decision-making requires adult cognitive skills. These skills develop in later adolescence, allowing an individual to assess a number of possible actions, weigh the future consequences of each and rationally select the most appropriate choice. But in early adolescence, these skills are undeveloped, whether the individual has high or low self-esteem. Young adolescents are insecure about their self-worth, have fears and doubts about their own sexuality, and think in the here-and-now. These factors deter them from developing real intimacy, from understanding the complexity of mature sexual relationships, and from accepting their sexuality enough to plan ahead. Knowledge of reproductive facts and availability of contraception are not sufficient at this stage of development for preventing pregnancy, because they simply cannot see the future consequences of their actions. They may believe that they are operating from a standard that sex is acceptable if they are in love. But they lack the intellectual development to know that they are not doing what they think they are doing. As some educators contend:



While sexual activity has begun at earlier ages, the development of cognitive skills has not. Parents, educators and professionals working with adolescents need to address this by being aware of how the thinking process works with young adolescents, by teaching decision-making at all stages of development, and by setting clear limits and standards for young people who do not yet have the ability to do this for themselves.

aspirations and opportunities

Aspirations are also a learned behavior. Like self-esteem they reflect how a teen feels about her/himself.

Aspirations might include thoughts of:

goals	plans	wishes
ambitions	intentions	yearnings
objectives	desires	cravings
purposes	longings	aims
dreams		

Aspirations drive individuals to do more and be more than they presently are. We may know what we are, but we can not know for certain what we can be. Therefore, it is necessary that we be guided and motivated by aspirations.

Aspirations, whether about education, career or quality of life are influenced by the communicated expectations of the people who are the most important in a child's life. If those expectations are high and consistent throughout their lives, there is greater chance that the teens' self-aspirations will be high. Similar to the way self-esteem is developed, if the expectations from a child's family is low, the result will be low aspirations as well.

The impact of low aspiration is seen among teens who become parents. Pregnant teenagers who choose to carry their pregnancy to term and who do not choose adoption are more likely to have low educational and occupational aspirations, low self-concept and self-confidence, less sense of control over their lives, and less education (Flick, 1986)

Maine youth appear to have lower levels of academic and career aspirations than other youth their age.

Research has shown that freshmen entering the University of Maine at Orono, 85% of whom graduated from Maine high schools, rate themselves above their

national agemates in their academic abilities, but lower than other young people in terms of leadership ability, social confidence, and drive to achieve. For example, more Maine youth choose to attend college without having a specific career goal in mind than their peers from across the country. (McIntire and Pratt, 1984)

A survey of the aspirations of high school students compared rural to urban youth. Since Maine is a rural state, much of the research is related to Maine students. (High School and Beyond, 1982)

It was found that rural youth value their jobs and making money more and their academics less, than urban students. greater percentage of urban students than rural students report that the goal of being able to give their children better opportunities than they had was very important to them. Rural students do not aspire to post secondary educational opportunities, are not as confident in their abilities to complete a college education, and do not see themselves as completing their full-time education at a younger age as frequently as urban youngsters do.

Rural parents are perceived as much less often supportive of full-time college than their urban counterparts and more supportive of full-time jobs, trade schools, and the military. Students from rural settings report more often than their urban counterparts that their guidance counselors and teachers do not think they ought to go to college.

Rather consistently, the rural students depict themselves less often in higher level positions, and more often in lower level, less skilled areas. The mothers of rural students also hold lower expectations for their children's ultimate level of education than the mothers of urban students.

Maine educators concerned about the aspirations of Maine youth have conducted "aspirations conferences" to focus on strategies and policies that might improve the goals and ambitions of teens. The conferences revealed that aspirations among Maine youth vary from region to region.

"The young person who grows up on the Maine Coast working for summer residents and tourists is apt to have different aspirations from the young person who grows up inland in a Maine milltown or on a potato field in Aroostook County. And a young person who grows up in the greater Portland area is apt to have different aspirations from either of these other two." (Phippen, 1984)

There also exists in Maine an "inferiority complex." It has to do with the social and cultural isolation found in many Maine towns and rural areas. There are parts of Maine where an individual, when asked how to get to a neighboring town, will answer, "I don't know, I have never been there." Although Yankee determinism and pride flourishes in Maine, strong traditions on the importance of home, land, family and community may create lower aspirations for careers and making money, especially if these would require a geographic move. There are few careers available to Maine students which offer high socioeconomic status. If money is not available in a teen's family, academic scholarship is unavailable, and no one else in her family went to college, she will most probably not aspire for academic achievement and challenging careers. Furthermore, as a high school student, a teen may not have a teacher who will be able to motivate him or her to achieve.

Motivation can be influenced by family and peer pressures, age, sex, curiosity, self-concept and the need to please others. But for many teens, motivation and aspirations are linked to the lack of opportunities for a good paying job, a successful career and, ultimately, a hopeful future.

the conclusion

Of all the differing values and beliefs that exist among Maine citizens about adolescent sexuality and teen pregnancy everyone agrees on one critical area: the importance of the parent/child relationship.

First, we must recognize the ample opportunities available to parents during infancy and early childhood to impact on the skills, qualities and attitudes of their children. As a society we pay little attention to the conditions and the behaviorally and emotionally transmitted expressions which surround infants, children and teens. We have a tendency to wait for a problem to occur before we focus on family need.

Good parenting requires hard work. Children do not come with instructions on how to raise them properly, how to prevent any harm from occurring to them or how to assure that they make the best choices in their lives.

Economic realities and the demands of work offer parents little time to be involved with their children and threatens their ability to take an active role in their development. Parents need skills and guidance in responding to the impact of recent changes in family life.

The parents' ability to provide a loving and secure home is directly linked to teenagers' decisions about pregnancy. This does not place the blame for the teen pregnancy problem on parents any more than we can blame teenagers for their confusion and misinformation about sexuality and pregnancy. It does point out, however, that our children need healthy parents and a healthy home for them to develop into successful, responsible adults.

We recognize that parents are the most important forces in the lives of children and youth and we also recognize the importance of other segments of society — supportive adults, trained professionals, and peers — offering support and guidance to teenagers.

The Task Force recognizes the importance of fostering high self-esteem, future aspirations and a sense of responsibility in both young men and women. But we see that sexual maturity among adolescents tends to define new boundaries between the parent and child. When the adolescent engages in sexual activity, more than any other activity, it symbolizes the impending separation from their parents. It can be a very threatening and confusing time for both parents and teens. We recognize the need for parents to communicate to their children not only accurate information about sex and sexuality, but also their values and beliefs about sexual activity. In turn, parents need to listen to the developing values of their teenagers, and help them understand their own feelings.

The charge to the Task Force was to develop strategies to prevent pregnancy and parenting among adolescents. We have looked at the roles of everyone involved in the lives of children and youth. We looked at the family, the teenager, the community, the clergy, the media, educators, health and medical professionals, employers and business, and social service professionals. And, as members of a citizens council appointed by the Governor, we looked at government's role.

We recognize that there is little if anything that government can do to affect the teenager's decision to delay sexual activity. Moreover, direct efforts to do so conflict with what is generally viewed as a private or family concern. (Moore & Burt, 1985) Government can not, and must not legislate morals, ie., that teenage sex is immoral; but in our vigilance we should not neglect the obvious: that in matters of sex, abstinence is the best contraceptive. (Kimball, 1986) The Task Force does not make decisions about teenage sexual activity; whether it is right or wrong or whether one teen is more ready than another. We recognize the importance of the teenager making the decisions about sexual activity and pregnancy within a framework of family values. But we do believe that the younger the teen the less prepared she/he is for sexual activity and the more serious the risks of pregnancy are to the teen mother and her baby. The Task Force believes it is more appropriately the role of parents, churches/synagogues and community organizations to establish values about adolescent sexual activity. At the same time, government can assist in preventing unwanted pregnancies by responding to those who are sexually active and by providing leadership to reduce the adverse effects of teen parenthood. Government must adopt aggressive programs that help teens and adults alike to be good parents.

We do not promote contraceptives for teens who are not sexually active, but we do believe that if a teen male or female is going to have sex, even once, an effective contraceptive method must be used. We do not recommend one outcome of pregnancy over another. But we do recognize all legally available options. We believe that young men and women have very difficult decisions to make once there is a pregnancy. We do recognize all legally available options including abortion. We do not believe that young women use abortion as if it were simply a form of birth control. We believe that there is a pervasive non-acceptance of the choice of adoption among teens and parents alike. And we recognize that teen marriages often fail and that our economic environment creates severe odds against the teen who is trying to balance continued education, employment, parenting and a successful marriage relationship. We believe that young women should have comprehensive, non-directive counseling combined with the support and love of their family so she can make the decision which is best for her. Designing strategies which prevent pregnancy will prevent the need for the difficult choices faced with an unintended pregnancy.

We recognize that pregnancy among adolescents is not limited to the teen living in poverty or in families with serious health and social problems, and that in Maine, pregnancy occurs across all income, religious and family backgrounds. But we acknowledge the likelihood that among high-risk youth with low self-esteem and few aspirations for their futures parenting is often viewed as a desirable role.

Providing improved self-esteem, aspirations and opportunities to build successful futures for young people, together with increased decision making skills, accurate information, and effective contraceptives, will enable teens to avoid early, unintended pregnancies and postpone parenting until later in their lives.

But it is clear that there always will be some teens who become parents unless aggressive, systemic change takes place in their behalf. We must backup our messages with action: that if teens wait to have children, the payoff in education, employment opportunities and good health will be worth while.

We must diminish the barriers that prevent young people from realizing successful futures. The world of the teenager is a microcosm of adult competition, prejudice and survival. Adult language like "illegitimate child," "fatherless household" or "juvenile delinquent" creates a barrier to success by limiting the expectations of many youth. It also tells kids to judge each other with labels like "slut," "loser," "druggie," "preppie" or "jock." Teens need positive peer pressure and good adult examples. They need to be accepted by their peers and be able to compete on equal grounds.

We will not be able to raise the aspirations and sense of hope of lower economic, high risk teens whose basic needs for food, housing, education and health have gone unmet. Under these conditions they have little hope of earning decent incomes, or developing good work attitudes when they lack basic job skills and occupational knowledge. They need real opportunities for self-sufficiency so they can envision a successful future. Until there are significant socio-economic changes which make available rewarding jobs with livable wages for all families with children, we can not assure teens of a healthy, secure future. If a young person in Washington County can not think of anything better to do than get pregnant at 15, with every intention of raising several children in poverty, then we have failed to help her envision a bright future.

Other equally important changes must occur. We must work hard to change the distortion of our sexual identities that is pervasive in the media. We must recognize the sexual inequity in society which portrays a double standard for male/female decision making about sexual activity and responsibility for pregnancy. We believe that sexual decision making must take place within a framework free of exploitation. This means learning to raise our children so that both males and females take responsibility for sexual decisions and share an equal sense of opportunity for the future.

Until the importance of parenting, and consequently the importance of children is recognized by business as well as government, children will not be able to fully receive the care they need. Children and families need basic family supports, and quality, affordable child care programs. Yet these, like local recreational programs for youth, are the first to go at budget cutting time. We must make youth services a priority, rather than a dispensable item in our budgets. But Maine can not do it alone. It will take national commitment and action.

National leadership in both the public and private arena is needed for Maine to embrace important new programs like maternal and parental pregnancy leaves, basic income guarantees for every child, or child support and AFDC indexed to a cost of living scale. We have to be willing to create equitable tax laws and design supports for families that accommodate parenting responsibilities while at the same time assisting families towards self-sufficiency.

The Task Force recognizes that systemic cultural change will take time. In the interim there is much that Maine citizens can do about raising healthy children who will make healthy decisions during adolescence and throughout their lives. Among the most critical of their decisions will be choosing a healthy sexual identity that delays the onset of pregnancy and parenting until adulthood.

THE CHALLENGE:

who is the challenge for?

The Task Force challenges you: Maine parents, teenagers, community members, educators, clergy, media, professionals from health, medical and family support fields, employers and government, to respond to the problem of teen pregnancy and parenting in Maine.

what can we do?

the goals

Central to the problem of early, unintended pregnancies among adolescents, is the ability to make healthy decisions. The Task Force believes that learning the values, skills and goals for healthy decision making is a lifelong task. It begins with healthy parents, and is reinforced by them throughout their child's life. But, just as a child grows up in a family, parents and families exist in a larger world. We believe that families should have access to the support and the assistance of helpful community members and systems designed to respond to their needs. To the best of our ability, we recommend to you ways in which we—in all our various roles with children and youth—can empower them to be responsible about their sexuality and to make healthy decisions about their sexual behavior.

Our recommendations are numerous and comprehensive. They address ten populations of citizens who we believe are in a position to impact on teen pregnancy and parenting. We have responded to the question: "What can we do?", but we have also answered, "How?" This represents hundreds of strategies. So that you can understand how parents, teens, communities and professionals have overlapping involvement, we have reduced our recommendations and strategies to eighteen statements of goals. Our goals address all teenagers from all backgrounds and in their various stages of development. They include teens who say no to sex, teens who are sexually active, teens who are pregnant and teens who become parents. They also address young children who are not yet teenagers. If each of us do our share, we believe that these goals will lead us to a reduction in the incidence of teenage pregnancy and minimize the adverse effects of teen parenting in Maine, and ultimately lead to a healthier society for us all.

Towards that end, on behalf of all teenagers, we should work to:

1. build on our children's developing sense of self-esteem.

Parents can provide the foundation for the development of a healthy child through love, time spent together, positive reinforcement, and opportunities to build strong character.

The community can increase opportunities by offering volunteerism, appreciation, special roles, and support for teenage needs.

Government, schools and the social services' community can offer support through the development and funding of specific programs that build self-esteem.

Media can promote healthy images for children and adolescents.

2. increase the aspirations of our youth.

Parents, with the help of the community, can instill in their children that they have a chance at a productive future, that they can aspire for great things and that parenting and childbearing are worth waiting for.

For those families, however, who are caught in an economically depressed cycle where opportunities for their children are lacking:

Community, schools, businesses and government can aggressively seek to involve high risk kids in experiences that will enhance their futures and build their hopes for succcess: career exposure, counseling, respect for jobs of all status.

Society and the community at large can diminsih restrictive labeling of youth and the unnecessary barriers to opportunities and success.

Social services and government can develop, support and fund programs to increase aspirations among teens, and to provide self-sufficiency for their families.

3. provide opportunities for economic success for our youth.

Families can help their children towards academic and job success.

Community, schools, businesses, and government can offer job training, career development, and apprenticeships, and reduce the barriers to employment for youth.

Society at-large can ask teens to be productive, contributing members of their communities based on age appropriate abilities.

4. increase opportunities for youth to learn decision making skills

By practicing decision making in family decisions in the home, by being given responsible roles in the community, and by having active decision making roles in schools, teens can learn to make responsible decisions.

Community, social services and government can design and fund programs that provide opportunities for teens to learn decision making skills.

5. provide children and youth with accurate information about sexuality and sexual behavior and about family life and parenting.

Parents can be the primary source of clear, accurate information.

Schools, through the comprehensive health education curriculum, can enhance learning in the home.

Experiential learning in school-based child care programs can build knowledge of parenting.

Government, community, the health, medical and social services' system can develop and support programs to provide information to teens.

6. provide clear messages regarding values, sexuality and preventing pregnancy for our youth.

Messages come from parents first, then the community, the school, churches and synagogues, businesses, health and medical professionals, social services staff and the media.

Messages should say it's okay to talk about sex, important to learn the facts, important to make choices consistent with family values, important to be responsible, and important to seek help.

7. improve parent-child communication skills especially on sexuality and sexual behavior issues.

Parents can learn how to communicate effectively by learning about their own sexuality, feelings, values and beliefs.

The community can offer opportunities for teens and their parents to interact and communicate with each other.

Government, business and service providers can offer specific programs for parents and teens to improve communication skills and success.

8. improve the skills of adult parents to raise healthy children.

Parents should become resources for their children as well as provide a healthy environment in which they can grow.

Parents can participate in parent education and public education activities in their communities, in parent companion courses and as advisors to the school based family life curriculum in their schools and in local self-help groups.

Media and employers can promote the importance of parenting.

9. promote activities to improve family relationships.

Parents can spend more time together with their children, listening to them and accepting them. They can seek outside help with resolving family problems or improving family interactions.

Clergy and the religious organizations can develop ways to encourage family cohesiveness.

Communities can develop an emphasis on the importance of family relationships, recognizing recent changes and diversity in family structure.

Businesses and employers can support families' needs through flexible work hours, job sharing, employer supported child care, employee assistance programs and policies that support families.

Health, medical and social service systems can incorporate a family systems approach to services recognizing the importance of family roles and relationships for the teen.

Government can design policies that strengthen families and at the same time respond to the needs of children and youth.

10. assure positive male involvement in pregnancy prevention and parenting.

Families can provide males with love, touching, and affection as part of their development of sexual identity and teach them responsibility for healthy behavior, including support for children they father.

Fathers can show their caring, vulnerable side to their sons; express their feelings to them; discuss emotional and sexual concerns with them; and provide them with reliable information about sexual behavior.

Community, schools, professionals and government can involve males in decision-making, and offer programs in positive role modeling, self-esteem building, parenting, and their support obligations to their children.

Media can enhance the image of the responsible, loving, nurturing male in his many roles as father, spouse, friend and others.

11. create opportunities for positive peer influence on teens.

Parents can support healthy, positive peer interaction.

Schools, communities, and government can sponsor peer support and peer counseling programs.

All aspects of the community: media, religious organizations, health and medical, and social services, can use teens as responsible agents to provide information to other peers.

12. provide other supportive adults for teens, recognizing that parents can not be all things at all times.

Parents can make available to their children other significant adults who can provide role modeling, meet basic needs that parents can not, provide information and offer their child a supportive relationship.

Community, professionals and government can design programs to provide supportive adults to teens.

13. create an organized community response to adolescent pregnancy and parenting.

Communities can provide leadership and take responsibility for developing ways to support adolescents, prevent problems and respond to problems that exist.

Communities can provide local action councils and an action plan to conduct public education and information activities; identify, coordinate and develop services for teens and teen parents; support parent and teen self-help groups; and advocate for changes in the media.

Teens, family members and representatives from various segments of the community concerned about teens should participate in the local action council.

Government can assist through financial support for the development of councils and implementation of action plans.

14. provide education and information to the public to enhance the ability of teens to make healthy, responsible decisions.

Public information on child development, communication skills, sexuality and sexual development, the roles adults play in the lives of children and the needs of adolescents is essential.

Community systems and government can work to design, develop and support specific initiatives that provide public education and information.

15. influence positive changes in the media for our youth.

Parents can become discriminating viewers, teach these skills to their children, watching media events with them and offering balanced points of view.

Media can become organized, on a statewide level, to offer positive, healthy information to children and youth free of sexual exploitation, and to promote responsible behavior and good parenting.

Community, agencies and government can develop media campaigns to support adolescents, promote healthy behavior and prevent pregnancy.

16. (a) provide to all adolescents primary health care services which are specialized to meet their developmental needs.

(b) provide reproductive health care as part of primary health and medical services to youth who are sexually active.

Parents can seek out community providers or government assistance for their teens, and give that information to them.

Health and medical providers can offer special services to teens in view of their varied needs: transportation, reduced fees, alternative hours, extra time and others. Information, referrals and linkages can help teens get health care.

Government, health providers, schools and communities can seek to reduce the barriers to primary and reproductive health care.

17. provide essential health, economic and family support services to teens and to families with children.

A healthy, secure teenager makes healthy decisions; those teens who go without life's basic needs are ill equipped to prevent problems.

The social service and health community can work with government and families to meet the basic needs for income, food, health care, housing, transportation and other essential family support services for children, youth and their families.

18. improve the skills of all professionals who work with adolescents and their families.

Adolescence is a special time between childhood and adulthood which requires particular skills and understanding among professionals who work with teens. Discussing sex and sexuality issues requires even more skill and comfort.

Families can seek out specially trained workers, and communities can advocate for training programs. Community professionals, private resources and government funding can engage in a partnership to assure teens that they will receive a compassionate and skilled response to their needs.

Professionals who need training and information include teachers, school personnel, peer counselors, community program staff, physicians, health professionals, volunteers and others.

The Goals for our teenagers represent nearly total consensus among Task Force members. Where disagreement took place is articulated in the section: Explanation of Minority Votes.

the recommendations

The following recommendations are in two parts:

Part One: Strategies for the Prevention of Adolescent Pregnancy and Parenting

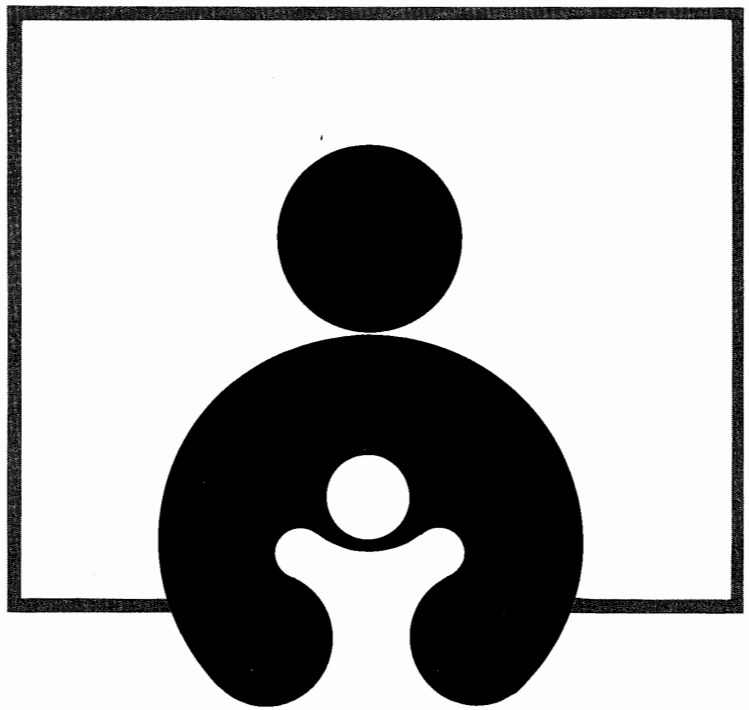
Part Two: Stategies to Minimize the Adverse Effects of Adolescent Pregnancy and Teenage Parenthood

NOTE:

At the end of each section of recommendations is a list of relevant program ideas and models, each of which is described in the Idea Bank of the Appendix. Those recommendations on which the Task Force did not reach consensus are noted, and the views of those opposed are presented under "Explanation of Minority Votes" following the entire recommendation section. The Government section includes any recommendations from the other nine sections which require government initiative or funding.

PART ONE:

strategies for the prevention of adolescent pregnancy and parenting



i. what families can do.

Parents and families play a critical role in helping their children develop by providing love and nurturing. They meet the primary needs for their children's survival. They empower their children with knowledge, skills, and a positive sense of identity, including the development of a healthy sexual identity. Together these building blocks help the child to create a responsible lifestyle and secure future and to experience basic happiness.

Sometimes families have too many problems to meet their children's basic needs or provide an environment in which the child can be healthy. There may be problems like chronic unemployment, alchoholism, mental illness or violence. The family may be in transition or not able to cope with serious economic problems. It may lack information or the skills needed to help the child. These families will need special assistance and their children will need other supportive adults who can provide what their parents cannot. In severe cases, some children will need another family.

The Task Force provides the following recommendations for all families, in their various forms and in all their different circumstances. We offer to you as parents and family members, specific ways in which you can assist your child to develop a healthy sexual identity, plan for responsible sexual behavior, and postpone pregnancy and parenting until after adolescence. We recommend that you:

a

Build on your child's developing sense of self-esteem.

1. Initiate, seek out and participate in parenting education programs and parent support groups which emphasize child development, communication, trusting relationships, positive reinforcement, unconditional love and the power of parental example.
2. Increase the amount of time you spend alone with your child, especially the time in which your child is actively listened to and accepted by you.
3. Help your child to know other adults who are good examples, who can meet their basic needs when you cannot, who will provide information and will offer your child a supportive relationship.
4. Provide opportunities for your child to be involved in family decisions at every stage of childhood.
5. Help your child become aware that actions have consequences for which he or she will be held responsible. This means allowing your child to learn from mistakes.
6. Provide your child with opportunities and options for the future to the fullest extent within your power. Teach your child to aspire to his or her full capacity and to build a sense of hope throughout childhood and adolescence.

b

Provide clear messages to your child about the positive aspects of sexuality, postponing sexual activity and preventing adolescent pregnancy. Messages which reflect family values and are based on accurate information need to be presented throughout childhood, not just during adolescence.

Parents, generally, want to influence their children in the important decisions throughout their lives. This is particularly true when teens are deciding whether or not to have sexual intercourse. There are times when parents can be with their children for critical life decisions to offer guidance and support. However, it is clear that decisions about sexual behavior occur when parents are not present. At this point the adolescent has control of the decision making. It is at this time that parents hope that everything they have said, taught and discussed with their child will be remembered. They can only trust in their child's good judgment and sense of responsibility.

The Task Force believes that the younger the teen the less likely he or she will have the knowledge and decision

making skills to recognize the risks involved in early sexual activity. Young teens are more likely to have social, emotional, developmental and health problems as a result of their sexual activity. They are at a greater health risk if the sexual activity results in pregnancy.

Realistically, older teens will be choosing whether or not to engage in sexual activity. Research indicates they are more likely to be responsible about their sexual activity. Many may feel they are prepared to face the consequences of pregnancy; they may be involved in a long term committed relationship or may be intending marriage. As a parent, encourage your teens to to make choices that are consistent with your values.

providing clear messages

Families have different values and beliefs about when it is appropriate for adolescents to become sexually active. As adolescents develop their own values and beliefs, the most important message THAT YOU AS A PARENT CAN GIVE IS THAT YOU CARE ABOUT THIS PART OF YOUR CHILD'S LIFE AND WANT HER OR HIM TO MAKE RESPONSIBLE DECISIONS. However, the Task Force believes that messages about sexual decision making which will provide clarity and direction for teenagers are:

1. It is important to talk about sex, feelings and values. It is important for young people to discuss these issues with their parents, other significant adults, and their peers.
2. It is important for parents and young people to learn accurate information about sex and adolescent sexuality.
3. Parents would like adolescents to make their decisions based on parental values. Since different parents have different value systems, messages the Task Force has heard include:

   a. "You ought not to have sex before marriage."

   b. "You ought not be be having sex at a young age."

   c. "You ought not to be having sex but if you do you have a responsibility to prevent pregnancy."

   d. "You ought to decide for yourself when to have sex but you should protect yourself from an unintended pregnancy and avoid unhealthy or exploitive relationships."
4. Parents can help teens develop their own values by listening and responding to their teens' values and beliefs.
5. There are resources available designed to meet health, medical and social service needs of teens.

   The Task Force and service providers believe that it is preferable for teenagers to involve their parents in the major decisions about their sexuality, sexual behavior and health. However, many of these services are legally available directly to the teen without the consent of the parent. Parents should, consistent with their own values, inform teens of the resources available and how to obtain them.

C Talk to your child, work to improve the quality and quantity of communciation between you, especially on the subject of sex and sexuality. Communication includes a dialogue whereby ideas are discussed openly and frankly.

1. Seek and participate in communication skills training which offers opportunities to learn how to talk about teenage sexuality and sexual behavior, and also offers opportunities for teenagers and adults to communicate with each other.
2. Develop a better understanding of your own sexuality and of your feelings about your child's sexuality. Help your child to understand your values and beliefs.
3. Learn about child development and how children learn values, attitudes and beliefs. Understand the influence of role models.

d Provide your child with accurate information about their sexuality, sexual identity, sexual development and sexual behavior.

1. Seek accurate information about sexuality and sexual behavior in order to correct the many myths and inaccuracies children learn from each other.
2. Support and participate in the development of your school, or church, and synagogue's program for family life and sexuality information. This will augment your instruction in the home.
3. Work for appropriate training of teachers to provide comprehensive health education in your child's school.
4. Become more discriminating about mass media such as television, movies, videos, radio and music, and with advertising in magazines, billboards and newspapers. View media together and discuss what you see with your child so that she or he can receive a balanced and informed account of the material.

e Work to assure that your child has access to age appropriate comprehensive health care which includes services appropriate during puberty and responsive to sexual development.

1. Seek out local community providers or government assistance to provide your child with comprehensive health care services.
2. Support the availability of community health programs which provide specialized services to meet the needs of adolescents, including reproductive health care.

   This recommendation did not receive approval from certain Task Force members who do not support the use of contraceptives. Please see the "Explanation of Minority Votes."
3. Support the development of school based clinics to provide comprehensive health care. High school clinics can help to alleviate problems of access to age-appropriate primary health care.

   This recommendation did not receive approval from certain Task Force members because they do not support school based clinics. Please see the "Explanation of Minority Votes."

f Support programs in your community which provide children with an opportunity to interact with peers in a healthy and positive manner. Peers can play an important role when problems exist.

The following list of programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

Big Brother/Big Sister
Bonney Eagle High School's Peer Group
Boys and Girls Clubs of Greater Portland
Camp Kieve
C.I.E.—Community Information and Education (See Family Planning - Community Information and Education Program)
DuSable High School's Health Clinic
Maine-ly Men
March of Dimes—Seminars for Parents: Communication with Our Children
Office of Family Life Ministries—Parent Teen Communication Workshops on Issues of Sexuality
Parent Resource Center and The Parent Connection
Parenting Education through Headstart
Parenting Model for Surrogates
Parenting with Pat
PACT (Parents and Adolescents in Changing Times)
Parents Anonymous
Peer Counseling (See YWCA Intervention Program—Peer Counseling)
Peer Support Group at Bangor High School
Portland Foster Grandparents
Portland Teen Health Programs
St. Andre's Education Program
School/Community Teams (See Division of Alcohol and Drug Education Services—School/Community Teams)
Scouting
Teacher Training Project (See Family Planning—Teacher Training Project)

"...I'm 17 and I have an eight month old son now. Parents either tell you not to do 'it,' or else they just don't say nothing and figure you'll get it in sex ed. Thank God for sex ed classes or I'd have had a kid when I was 14."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

ii. what teens can do

Teenagers have a lot of questions and concerns about sex. This is not surprising. Their bodies are changing and they are becoming more aware of their own sexuality. They often feel confused about the basic facts, the importance of sex in a relationship, and what is the right degree of physical intimacy for them. Our culture, as found in movies, music, advertising, and television often exaggerates the glamour and importance of sex. In addition, many teenagers report a lack of information about sex, sexuality and loving relationships.

They point to a lack of communication between parents, teachers and teenagers. Positive information about love, affection and relationships helps children and teenagers to communicate, to ask questions and eventually to make good decisions about their own sexual behavior.

teen to teen

In order to prevent early unintended pregnancy, the teen members of the Task Force recommend the ten most important things teens themselves can do:

1. **Participate** in programs to improve your self esteem. The better you feel about yourself, the more you will want to protect your future.
2. **Understand that no matter who you are, you are not alone.** It's important to find informed, understanding and caring adults who can help you through difficult decisions. Find out about counseling services and don't be afraid to ask for help when you need it.
3. **Control your own situations and make your own decisions.** You have a right and a responsibility to decide what degree of physical intimacy is right for you—the decision is yours, not your friend's, your boyfriend's or girlfriend's, your parents', your church's but **yours.** You must make this decision based on what you believe is right for you but at the same time you must respect your partner's decision about what is right for him or her.
4. **Males have equal rights and responsibilities in decision making.** These include the right to say yes or no to sex, the right to help decide what to do if your girlfriend gets pregnant, shared responsibility for the pregnancy, and the responsibility to understand that sex involves intimacy, feelings and values.
5. **Sex is not evil and should be talked about openly without discomfort.** Most people—teenagers or adults— need help becoming comfortable talking about sex. Look for informed or caring friends or adults who can help you feel that your concerns are really listened to.
6. **If your parents haven't talked to you about sex, talk to them.** Your parents may be more open to talking to you and listening to your concerns about sex than you suspect. Let them know your concerns and what you need from them to help you with your decisions.
7. **If you take a sex education class, don't be afraid to ask questions,** even if you have to wait until after class. It's just as much of a class as algebra, so take it seriously.
8. **Before you think about becoming a parent, think about being a parent.** Having a baby may look like a good way to have someone to love and to love you back; it may look like a positive step on the way to becoming an independent adult. Before you do, consider carefully whether or not you're ready for the financial, emotional and parenting work necessary.
9. **Explore your interests and get involved.** It's easy to see what's wrong with the world, your school and perhaps even your family. But making a better future for yourself means actively exploring ways you might be involved in the world.
10. **Do what's right for you, not everyone else.** Everyone has an opinion about what's right for you when it comes to sex. Get to know yourself well enough to know how to stand up for yourself, your needs and your view of what's right.

The Task Force looked at the issue of teen sexuality and pregnancy from the perspective of adolescent development, self-esteem, decision making and planning for the future. We tried to understand the social, cultural, spiritual and psychological factors influencing teens and we recognize that teens—themselves—are the ones in final control of decisions about their own sexuality. In order to help teens make better decisions—ones which assure the best hopes for a successful and satisfying future—we developed the following recommendations aimed directly at teens.

a

Recognize that you are in control of the decision whether or not to be sexually active; the choice is yours. Also remember that the responsibilities and the consequences of your decision are yours.

b

Look for clear mesages and guidance about sexual decision making from a variety of sources, including family, school, church or temple, other adults, and peers. Such messages might tell you:

1. It is important to talk about sex, feelings and values.
2. It is important to learn accurate information about sex and adolescent sexuality.
3. Find out what your parent's beliefs and values are about sexuality and sexual activity for teenagers and try to understand them. Your parents will want you to consider their values as part of your decision. Messages the Task Force has heard parents express include:
   a. "You ought not to have sex before marriage."
   b. "You ought not to be having sex at a young age."
   c. "You ought not to be having sex but if you do you have a responsibility to prevent pregnancy."
   d. "You ought to decide for yourself when to have sex based on protecting yourself from an unintended pregnancy, and avoiding an unhealthy, or exploitive relationship."
4. Express your values and beliefs to your parents and other important adults in order to help them to understand what you think and feel.

5. There are resources available to help you. Some of the services are, by law, provided to you confidentially and do not require permission or notification of your parents. Many are available at little or no cost. Reach out for services on your own when you think they could be of help to you, keeping in mind what's right for you based on your own values.

c

Explore ways to participate in programs which promote positive aspects of sexuality, build communication skills and decision making skills.

1. Participate in sexuality and family life education in your school, church or temple, or other community organization.
2. Join peer helper or peer counseling programs.
3. Look for innovative programs that help teens get information about their own values and decisions.
4. Find programs that help teens and parents communicate with each other.

d Create a vision about what you want for yourself in the future.

The first step toward a better future is to believe that it really is possible. It may seem hopeless at times because of the large social problems over which you have no control. Or, in families where there are serious problems like abuse, alcoholism or illness, it may seem impossible to build a hopeful future. But there are many people and opportunities that can provide you with a sense of the future and offer some direction for you. Seek them out.

The following list of programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

- Annual Teen Conference
- Auburn Teen Association
- Bonney Eagle High School's Peer Group
- Boys and Girls Clubs of Greater Portland
- Brunswick High School Forums
- Camp Kieve
- Family Planning Clinics
- Maine-ly Men
- March of Dimes—Seminar for Parents: Communication with Our Children
- Office of Family Life Ministries—Parent/Teen Communication Workshops on Issues of Sexuality
- Oh Boy! Babies!
- PACT (Parents and Adolescents in Changing Times
- Peer Support Group at Bangor High School
- YWCA Intervention Programs—Peer Networks

iii. what can the community do?

Communities have a broad and important role in the prevention of adolescent pregnancy. It is within the community that families meet their basic survival needs: employment, food, shelter, health care, etc. It is also within communities that families find companionship, emotional support and interaction with other families. Whether as an individual or as a community group, each of us has the opportunity to influence the healthy development of children.

The following recommendations may be directed to you personally, or at your community service organization or at your local governing body. The commonality with all the following recommendations is that they require local initiative, commitment and action. The Task Force recommends that you as a community:

a Encourage and support community action on this issues of adolescent sexuality and pregnancy prevention through the development of an organized community response.

1. Convene a local action council to provide leadership and take responsibility for developing a plan of action to be used for your community.

   The council should include, among others, teenagers, teen parents, parents, educators, government, policymakers, lawmakers, clergy, service organizations and providers of health and medical care and family support services.

   For the greatest success communities may want to build on already existing efforts. Some communities have organized groups to respond to adolescent pregnancy and parenting, child abuse, substance abuse and other child and family problems. Please see the Idea Bank in the Appendix for examples of community groups.

2. The local action plan should include plans for:

   a. Development of a community education process which will increase interest in and understanding of teen sexuality, reproductive health issues, pregnancy prevention, and adolescent parenting.

   b. Identifying existing services for pregnancy prevention and for pregnant and parenting teens and creating other services that your local action council has identified as needed.

   Give particular attention to barriers such as transportation, cost, and lack of confidentiality, as well

as whether services are provided by someone who understands adolescence or is trained to work specifically with teens.

c. Supporting parents in efforts to establish and operate self-help and parent groups by offering meeting space, volunteer assistance or advertising.

d. Encouraging the development of peer support groups involving trained young people who provide counseling, communication and examples to other adolescents.

e. Teaching citizens to become more discriminating consumers of mass media so that they are better able to use media as tools for learning and communicating.

3. Locating and harnessing resources including funding, volunteers, physical space or other items necessary to carry out the mission of the local action council and plan. This includes securing federal and state funding sources.

b

Increase opportunities for adolescents to develop self esteem.

1. Encourage volunteerism among youth in community organizations such as day care centers, nursing homes, public libraries, fire departments, or small businesses.
2. Show community appreciation for the things that youth from all backgrounds contribute to their community; let them know that they count and that they make a difference.
3. Support activities and events which are specifically for youth; recreation, sports, dances, festivals, competitions, parties.
4. Allow and encourage teens on local boards or committees where allowed by law.

c

Promote community activities which serve to improve family relationships and to bring family members together.

1. Develop activities which blend different generations and families: recreational programs for multi-generations; businesses and restaurants that encourage the presence of children or provide discounts; and child care provided at meetings so citizens who have young children may attend.
2. Emphasize the importance of family relationships of all kinds through courses or badges in family life for members of Boy and Girl Scouts, 4-H Clubs, boys-girls clubs, church groups.

d

Increase opportunities for youth to learn decision making and personal responsibility.

1. Promote adolescent membership on Boards of Directors, committees or advisory groups for non-profit community agencies, municipal organizations and community endeavors such as Y's and church groups.
2. Create more opportunities for junior high and high school age youth to assume appropriate advisory and decision making roles in their schools.

e

Increase opportunities for success and raise the aspirations of youth.

1. Diminish labeling and the use of language that limits the achievements of children and youth.

   The labels in our language such as "illegitimate" or "acting out teenager" or "under achiever" not only limit specific children, but they teach all children to judge and label one another. Junior and senior high school students exist in a world which is torn apart by the limitations of labels: "losers, jocks, preppies."
2. Eliminate the unnecessary barriers to community activities, extra-curricula activities and vocational

opportunities that limit the participation of high risk youth.

Examples of unnecessary barriers are: lack of parental involvement excluding a child from sports, recreation or music programs; family finances preventing a child from participating in an activity requiring equipment; unfair reputation which prevents a child from being included, without any attempt to evaluate his or her capabilities and ambition.

3. Conduct aspiration-building activities in the schools and community offering youth contact with successful adults from all backgrounds and careers, regardless of the social or economic status of their jobs. Youth need to value all types of work in order to find dignity and self-worth in their own career path.

f Increase employment opportunities and preparation for self-sufficiency.

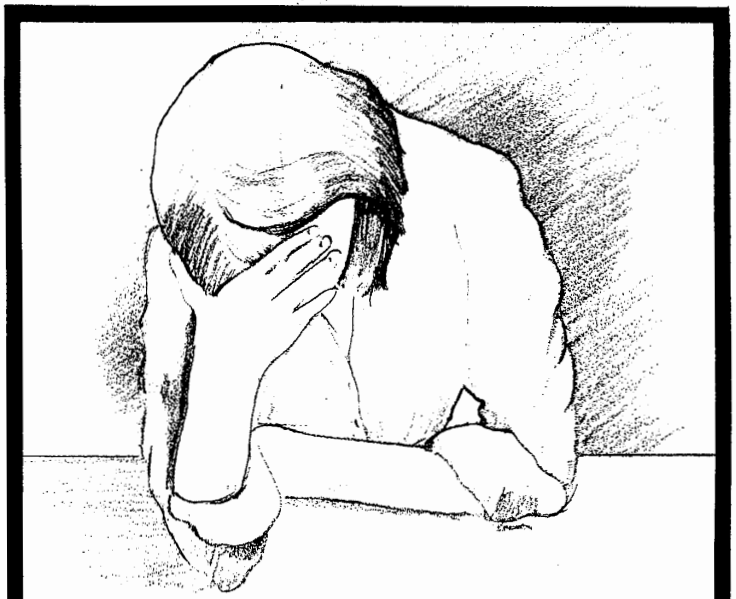
1. Support job shadowing and apprenticeship programs for high school age students.
2. Encourage local employers to create appropriate part-time jobs for teens.
3. Support exposure to career opportunities such as career fairs for younger children.

g Create opportunities for teenagers and adults of all ages to interact and communicate with each other.

h Explore cable access television as a low-cost community based resource available to utilize as part of media campaigns and public information efforts.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

Adolescent Pregnancy Child Watch, Children's Defense Fund
America's Future Award Program
Aspiration Conferences
Auburn Teen Association
Big Brother/Big Sister Programs
Career Conferences
Child Abuse and Neglect Councils
Children's Defense Fund—Media Campaign
Children's Trust Fund
C.I.E.—Community Information and Education (See Family Planning—Community Information and Education)
"Community Schools"
Community Women
Cooperative Education
Dream Jamboree
Family Planning Clinic System
Males Preventing Pregnancy
PACT (Parents and Adolescents in Changing Times)
Parenting Model for Surrogates
Portland Foster Grandparents
Project Graduation
Scarborough Emergency Medical Technicians Program
School/Community Teams (See Division of Alcohol and Drug Education Services—School/Community Teams)
Statewide Service Providers' Coalition on Adolescent Pregnancy— Regional Coalitions
Targeted Jobs Program



"My reaction when I heard the official news that I was pregnant was to cry."

FROM THE PLURALISTIC SOCIETY
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iv. what the educational system can do.

The educational system plays a major role in the prevention of adolescent pregnancy: the comprehensive health education curriculum provides students valuable information about the roles and responsibilities they have throughout their lives. They learn how to be healthy and what society expects of them as parents and members of families and communities. Inherent in learning about family life is learning about teen development, changes in their bodies, and sexuality.

The Task Force believes the educational system can go beyond its responsibility for academic and vocational training by encouraging students to build aspirations for their futures, make responsible decisions, and develop healthy lifestyles. The following recommendations are designed to make early pregnancy and parenting a less desirable option and to develop responsible attitudes about sexual behavior. We recommend that schools:

a Assure the implementation of Family Life and Sexuality education from kindergarten through high school graduation as part of a comprehensive health education curriculum.

1. Promote companion courses to help parents and other adults become more informed and comfortable with their own sexuality, adolescent sexuality, and the sexuality education curriculum that is provided to their children.
2. Work to change the rules and regulations governing teacher certification so that teachers who are responsible for delivering the curriculum are specifically trained in comprehensive health education including family life and sexuality education and that they regularly upgrade their knowledge and skills.
3. Develop a curriculum or utilize an existing curriculum which includes accurate information, clear messages to teens, ethical values and decision making.
4. Promote a positive role for males involving them in co-ed discussions about sexuality, sexual decision making and responsibilities. Promote a curriculum which changes the stereotype of the uncaring, irresponsible male to acknowledge the needs and capabilities of both males and females for love, nurturing and affection.
5. Develop and promote a network of local advocates for family life and sexuality education to assist with community support of the curriculum.
6. Support local involvement through the development of a parent advisory group for curriculum development and/or a controversial issues committee to assist with the implementation of the curriculum. This committee can also respond to the differing value systems of parents of school children in the community.
7. Seek out and encourage other community institutions such as churches, youth groups and service providers to augment the school curriculum with their own companion courses and activities.
8. Seek out and utilize the assistance of the Department of Educational and Cultural Services (Division of Curriculum), and the Maine School Management Association for planning and developing the curriculum.
9. Promote and utilize up-to-date resources such as age-appropriate literature, films, and texts which reflect community values as defined through the advisory committees and school personnel.
10. Include in the curriculum information about local resources, such as counseling, physician or health clinic services, peer counseling groups, self-help groups and hotlines, which are available to respond to the diverse needs of children and their families. Make this information available to parents.

b

Promote peer helper programs and support groups:

1. Expand the existing network of peer counseling programs throughout the state.
2. Develop a working relationship with existing youth organizations in the community (such as Boy Scouts, Girl Scouts, YMCA, YWCA, 4-H). Promote the development of educational and peer support activities which focus on sexuality.
3. Develop self-help groups to deal with issues of teen sexuality.

c

Advocate a student-centered approach which offers active decision making roles for youth and diverse opportunities for success within Maine schools.

1. Provide opportunities for youth to participate in making decisions about school curriculum and about the school environment.
2. Develop teen-centered work groups which focus on promotion of good health.
3. Make a special effort to involve youth who are at risk of school failure, pregnancy and other health and social problems in these programs.
4. Eliminate the unnecessary barriers to extra curricular activities and vocational opportunities that limit the participation of high risk youth.

Examples of unnecessary barriers are: lack of specialized help for students doing poorly; inability of students to acquire equipment needed for participation; and unfair reputations which prevent a child from being included without any attempt to evaluate her or his capabilities or ambitions.

5. Conduct aspiration-building activities offering youth contact with successful adults from all backgrounds. Include adults who are engaged in different kinds of careers regardless of the social or economic status of the job.
6. Support exposure to career opportunities for younger children such as career fairs.

d

Provide aggressive programming for youth who are at risk of pregnancy.

1. Provide alternative education programs for junior and senior high students who are at risk of academic failure, dropping out of school, pregnancy, substance abuse, delinquency or other related problems.
2. Provide intensive out-reach and follow-up programs for students who drop-out of school to enable them to complete their education, using peer support groups where posssible.

e

Work with government and community agencies to promote linkages between school and community services.

Use local resource people in the classroom, such as health care workers, social workers or teen parents.

f

Promote family cohesiveness through the development of school programs that involve adult participation, such as plays, dances and classes for multi-generational learning. Provide on-site child care so family members can attend.

g

Promote the concept of schools as a site for wellness and health promotion for adolescents through the development of school based comprehensive health clinics in or accessible to the community high school.

1. Explore with community groups the interest in and support for school based clinics which provide basic health services including services which address pregnancy prevention.

2. Examine the availability of comprehensive health services for adolescents in the community. Assess the cost, appropriateness and confidentiality issues for existing health services.
3. Examine the issues of parental involvement, parent's rights, teen rights and the unmet health needs of teens.
4. Apply for funding to implement school based comprehensive health clinics where community interest and support exist.
   This recommendation did not receive approval from certain Task Force members because they do not support school based comprehensive health clinics. Please see the "Explanation of Minority Votes."

h Encourage school-based child care programs which are integrated with support groups for teen parents, as well as with family life and child development courses involving both males and females, and with return to school programs for teen parents. Child care programs should be integrated into the community by making them available to school personnel and local families.

i Promote community schools and the use of school buildings to offer extra-curricular activities that strengthen family life such as recreation, child care, parenting classes, support groups.

j Encourage post-secondary schools, colleges and universities and agencies with expertise to offer basic and advanced training in family life and sexuality education for front-line workers involved with children and their families, as well as for teachers. The post-secondary system should also be encouraged to conduct basic and applied research in this field.

k Promote social responsibility and youth involvement in their communities by adding a public service requirement for college admission.

l Support and advise community, statewide agencies and government groups in the development of media campaigns on parenting, sexuality, adoption and other related topics.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

- Annual Teen Conference
- Aspirations Conferences
- Bonny Eagle High School's Peer Group; Day Care and Parenting Center
- Brunswick High School Teen Forum
- Bureau of Health Library; Maternal & Child Health Library
- "Community Schools"
- Cooperative Education
- Day Care Practicum at Hampden Academy
- Dream Jamboree
- DuSable High School's Health Clinic
- Family Planning—Teacher Training Project, Public Education Training, Community Information and Education
- Living Skills Development Course
- Maine School Health Coalition
- Oh Boy! Babies!
- Peer Support Group at Bangor High School
- Portland Teen Health Program
- School Based Health Clinics
- School/Community Teams (See Division of Alcohol and Drug Education Service—School/Community Teams)
- Wells Community School District—Health Education Teacher/Coordinator Position
- YWCA Intervention Program—Peer Counseling

"As long as you teach about pregnancy, you will get pregnancy; just as it is true that as long as you teach about drug abuse, it will flourish."

FROM THE PLURALISTIC SOCIETY
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v. what the clergy and religious organizations can do.

Just as it is clear that our culture reflects the pluralism of diverse views and values, it is clear that the religious organizations in Maine also reflect a diversity of theologies and attitudes toward the major social issues of our time. The issue of the prevention of adolescent pregnancy and parenting is no exception. In this report we make no attempt to resolve divergent views. Beyond religious differences, we believe there are enough common areas of agreement that will allow varying religious groups to work together around the issues of teenage sexuality. Those who cannot are encouraged to develop and carry out their own programs within their own groups.

We are also aware that many of the churches, parishes, and religious communities in Maine are small groups, that the work of the clergy is often generic and their time is spent in many directions. Through preparation for ministry and in the course of daily work, little time and few opportunities are available for special education in adolescent development and sexuality. As a result, religious groups often lack trained personnel and find it difficult to recruit adults willing to work with teens. For some religious groups these barriers have been overcome. There are programs in family life, parent education, parent-teen communication, and sex education in many churches and synagogues throughout Maine. We encourage others to work toward developing similar programs.

In summary, we believe that many teens are confused about their own values regarding sexual behavior and the beliefs and convictions of their parents. We believe the religious communities in Maine can play an important role in getting more directly involved in teaching their sexual values and attitudes to their congregation and in assisting parents in communicating family values more directly and clearly to their children. We make the following recommendations to be considered by the religious organizations of Maine at both state and local levels:

a Develop family life committees for the purpose of (1) providing education, training, and resources, (2) strengthening families, marriages and parent-teen relationships, (3) providing sexuality education, and (4) creating responsible roles for teens in carrying out the goals of their churches.

1. Urge organizations in Maine representing more than one religious group, such as the Maine Council of Churches, to establish family life committees for its members.
2. Urge interdenominational and denominational religious groups to develop family life committees as a resource to the work of local family life committees within their organizations across the state.

b Develop and provide training opportunities for clergy, religious education teachers and youth leaders in family life issues, parenting, sexuality education, and adolescent development.

1. Urge the Bangor Theological Seminary to assume a leadership role by offering sexuality education to its students.
2. Encourage cooperation between the clergy, religious groups and the Maine Department of Human Services and others with expertise in developing programs for education and training in matters of family life, marriage, sexuality, and knowledge of local resources. Hold an annual clergy conference with the Department of Human Services on these issues.

c Develop and teach programs within your faith group to strengthen family life.

1. Teach the meaning and value of sex and sexuality as it relates to personal growth, and development.
2. Prepare couples for marriage, including their sexual relationship.
3. Provide ways of maintaining and continuing strong marriage relationships, including sex and its role in marriage.
4. Offer clear messages of support and affirmation for family life and marriage at a time when society is questioning the values and meaning of marriage.

d Provide support for parents as the primary educators of their children in life values including sexuality education.

1. Provide programs to help parents learn good communication skills and sex education.
2. Encourage parents to become actively involved in the development of family living courses in the public schools to insure that family values are respected.

e Support and involve young people as they move through the critical adolescent years.

1. Develop youth ministries and peer ministries.
2. Involve youth in decision making roles in church organizations giving them opportunities to relate with adults who may be important role models.
3. Increase the efforts to make known the basic religious proposition that all persons have worth in and of themselves.

f Further the work of social justice throughout Maine communities and government in an effort to eliminate the milieu of poverty, despair, domestic violence, and child abuse that affects teens and their families.

g Promote Annual Conferences on Family Life and Marriage, parent-teen relationships, and human sexuality involving religious organizations, teens, families and professionals. Provide them throughout Maine communities.

h Promote an active role in the media by the clergy community with strategies including:

1. Sponsor a screening of media spots (public service announcements) and offer interfaith endorsements. Responsibility: The Maine Council of Churches.
2. Offer public service announcements regarding positive role models for teens, especially for the teens who are not sexually active and for good parenting by teens who already are parents.

i. Develop an interdenominational statewide resource library to be made available to all denominations, and to include non-denominational material. Provide a clearinghouse for conferences and educational programs so that a wider audience could be formed. Responsibility: Maine Council of Churches.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

Marriage Communication Laboratory

Office of Family Life Ministry—
Parent/ Teen Workshops on Issues of Sexuality

Quaker Teen Conference

vi. what can the media do?

The Task Force recognizes that the mass communication media, including television, radio, movies and print, are powerful cultural influences on teenagers. Too often the media promotes exploitive and irresponsible sexual behavior and displays casual sex without the consequences of pregnancy or the realities of parenting. The resulting effect on our youth is confusion. Teenagers need a balanced view of sexuality and accurate information. Media must be enlisted as a beneficial force for teens, parents and educators in the interest of preventing teen pregnancy.

a. The Task Force recommends that members of the media community:

Urge the Governor to convene a statewide group which would work to advise, encourage and initiate healthy, positive images of young adults and children in the printed and electronic media. The group should consist mostly of media professionals but also have representatives such as teens, parents, clergy, advertisers/business, professionals working with teens and others. This group should explore the impact of teen imagery on the lives of teenagers with particular attention to self-esteem, alcohol abuse, peer pressure and sexual abuse, all of which influence teen pregnancy. As part of their roles and responsibilities this group should:

1. Involve the Maine Association of Broadcasters and Maine Press Association as participants or advisors.
2. Encourage advertisers and sponsors to participate in pregnancy prevention by presenting less sexualized images.
3. Create an annual service award for the best media effort in promoting responsible teen sexual behavior.
4. Encourage and advise the media in methods of presenting balanced information on issues such as sexual development, contraception, abortion, and adoption to serve our broad pluralistic community.
5. Monitor existing media efforts and build on both local and national successes.
6. Promote central statewide planning and coordination of media efforts in adolescent pregnancy prevention.
7. Report findings to the Governor after one year and continue efforts for several years to improve images of youth in the media.

b. Identify ways for media to promote healthy images of children and adolescents, and reduce sexually exploitive messages.

"A complete knowledge of sexual and reproductive activities empower women's choices."

FROM THE PLURALISTIC SOCIETY
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c. Promote media campaigns that stress: the importance of parenting on the lives of children; the skills needed to raise healthy, responsible children; and the community investment in and shared responsibility for all children.

d. Support media and public information efforts initiated by the medical/health community to increase awareness of teen pregnancy and its prevention.

e. Encourage active and critical viewing to assist consumers in using the media productively, educationally and positively.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

- ACOG Ads (American College of Gynecologists Information Program)
- America's Future Awards Program
- Children's Defense Fund—Media Campaign
- Division of Maternal and Child Health Public Education Efforts
- It's Okay To Say No Way
- Males Preventing Pregnancy
- Parenting with Pat.
- Statewide Service Providers' Coalition on Adolescent Pregnancy: Primary Prevention Strategy.

vii. what can the health/medical community do to assist in the prevention of adolescent pregnancy?

Many teenagers do not seek medical care for prevention or routine health maintenance. The teens that do use health services often approach them with caution, reserve and shyness. This fact creates a barrier to quality health care. This is further complicated by the lack of health and medical services that meet the specialized needs of adolescents. Barriers to services include: transportation and scheduling; fee schedule, payment plan and billing policies; finding a service designed specifically for teens; and building a sense of trust in the confidentiality of the service. The Task Force believes that these barriers must be acknowledged and addressed by all health care providers to make services comfortable, accessible, responsive and well utilized.

The following recommendations address the health/medical community both as individual professionals and as organizations. The Task Force understands that the health/medical community is a diverse population including all levels of service providers in clinics, private offices and hospitals as well as health planners, educators and public health workers. The Task Force recommends that the health/medical community:

a. Promote and encourage teens to use health and medical services:

1. Recognize and respond to the relationship teens have with their families which often waivers between the dependence of childhood and the independence of adulthood.
2. Provide and participate in training for health care providers which addresses special issues for adolescents including,

   a. skills for encouraging parental involvement in a teenager's health care when appropriate;

   b. teen rights and the need for confidentiality of their health care services;

   c. characteristics of adolescent development including sexuality;

   d. skills which will help to communicate the importance and benefits of delaying sexual activity;

   e. skills to select appropriate birth control methods for sexually active teens and skills to teach the sexually active teen accurate use of those contraceptives;

f. issues of sexual abuse, substance abuse and other teen problems; and

g. responding to transportation, appointment scheduling and other barriers.

3. Initiate programs which train and use teens as health aides and health educators for other teens.
4. Initiate and support the development of comprehensive health services in locations that are accessible to teens including schools or teen centers.

b

Improve health services to teens:

1. Create opportunities for teens to serve in an advisory capacity for programs that serve teens.
2. Encourage the development of a current and thorough directory of medical and non-medical resources for teenagers in your locale.
3. Plan and develop policies that assist teens by eliminating barriers to services.
4. Support efforts to develop a comprehensive Informational and Referral System that is accessible to teens and their families and that includes information on teen health services. Build on existing successful models.
5. Advocate for changes in State Medicaid policy for reproductive health services to allow for non-medical care providers to be reimbursed for consultation and education time.
6. Call for the study of health care costs and methods to finance care, including the Medicaid system, to identify barriers to the delivery of health care to all teens.
7. Support amendments to the Perinatal Section of the State Health Plan for Maine to encourage hospital and other health providers to use the Certificate of Need process to develop comprehensive reproductive health care services for teens. This effort is compatible with the Department of Human Services' mandate to contain the cost and unnecessary expansion of health care in Maine.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

ACOG (American College of Obstetricians and Gynecologists Information Program
A.H.E.C. Grants (Area Health Education Center)
DuSable High School's Health Clinic
Family Planning—Clinic System; Public Education and Training; Community Information and Education
Family Services Program
Maine Consortium for Health Professionals Educators
Parents and Adolescents in Changing Times (PACT)
Portland Teen Health Program
School Based Health Clinics
Senior Health and Peer Counseling Center
Statewide Service Providers' Coalition on Adolescent Pregnancy

viii. what can the social service community do toward preventing adolescent pregnancy?

Many teens who experience unplanned pregnancies also report having feelings of low self-esteem and a lack of future aspirations. Conversely, teens who are eagerly anticipating their adult lives appear to be less likely to be involved in unwanted pregnancies. Social service programs that help teens to develop positive self-esteem, personal ambitions and options for the future can help prevent early pregnancy.

The Task Force recognizes two major types of social services. The first are entitlement programs providing services through federal and state funding, that are necessary for family survival, such as Aid to Families with Dependent Children, medical assistance and Food Stamps. Although most people do not consider these entitlements as prevention programs, we believe that basic supports such as food, income and health care are essential to the

development of healthy children and healthy lifestyles.

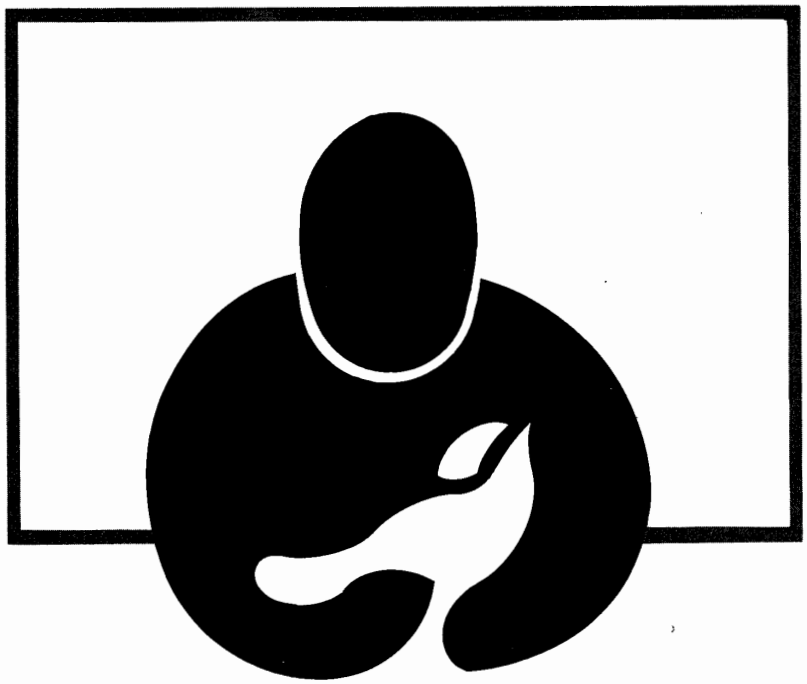
The second type of services the Task Force refers to are opportunity programs. These services are usually provided by private agencies through a variety of funding sources including government allocations and block grants. Opportunity programs offer both primary prevention and early intervention strategies to delay early sexual activity, and to prevent unintended pregnancy and parenting among teens. Prevention efforts are defined as those programs available to all children and youth **before** a problem occurs. Early intervention initiatives are designed to prevent problems and are offered to a specific population of children and their families who are identified **at risk** of a problem. The task force recommends that the social service community:

a Develop social services programs designed to build self-esteem, aspirations and decision making among children and youth that lead to the prevention of pregnancy.

b Encourage state agencies to make improvements in entitlement programs for Maine children and their families. However, the state should pay specific attention to whether or not programs, designed to provide adequate resources for families such as AFDC, Medicaid and Food Stamps, inadvertently provide an incentive to pregnancy or encourage teens to leave the family home.

c Provide funding to increase the support for front-line workers in both state and private agencies who have direct access to and responsibility for children, teens and their families:

1. Provide training opportunities on issues of child development, human sexuality, values clarification, effects of poverty, issues for appropriate family involvement and teens' need for and right to confidentiality.
2. Define reasonable workload policies providing adequate time for workers to know and work with their clients appropriately.
3. Provide adequate pay which relects the importance of their work and acknowledges the level of their responsibility.
4. Offer flexible work hours enabling them to design a work week which meets their own needs as well as the needs of their clients.



Front-line workers, whether they are state employees or employees of a private agency, have an enormous impact on teens and how teens view the social service system. Their work skills with all clients, but especially with teenagers, are greatly enhanced by experience and maintaining client relationships over a long period of time. Inadequate support for front-line workers leads to frequent staff turnover, making services to clients less effective.

d Support efforts to develop a comprehensive Information and Referral System that is accessible to teens and their families and that includes information on social services for teens. Build on existing successful models.

e Support the development of a public information campaign, designed to encourage teens to utilize the full range of services and opportunities available to them. Encourage teens to choose services that are appropriate to their needs, and to make decisions about sexuality. Utilize teen advisors for both the development and implementation stages. The Department of Human Services should initiate and participate in this effort.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

Big Brother/Big Sister
Boys and Girls Clubs of Greater Portland
Children's Trust Fund
Community Women
Division of Maternal and Child Health Public Education Efforts
Family Planning
Family Services Program
It's Okay To Say No Way
Scouts
Statewide Service Providers' Coalition on Adolescent Pregnancy: Primary Prevention Strategy
Male Adolescent Program
Portland Foster Grandparents
Project Responsibility
Scarborough Emergency Medical Technicians Program

ix. what can employers and the business community do for the prevention of adolescent pregnancy?

Most adults spend a majority of their time trying to balance the demands of two worlds: work and the family. These two worlds are interdependent with one another as the quality of experiences in one dimension effects the quality and vitality of the other. The employer and the business community can positively effect the world of the family by offering opportunities for employees to improve their roles as parents. Employers can influence teens in delaying pregnancy by developing opportunities for adolescents to work in the business community. The Task Force recommends that employers and the business community:

a Increase the participation of adolescents in the business community in order to build their self-esteem and to create a bridge between adolescence and working adulthood.

1. Develop jobs which are appropriate for the teenager's level of skill, need to learn and availability to work.
2. Participate in career learning programs such as job shadowing, internships, and apprenticeship programs which use an educational format to assign students to working adults.
3. Encourage partnerships between the public (government) and private (business) sectors to create employment and training opportunities for teens.

"We believe that if teens had more hope of finding jobs, establishing careers, and feeling good about their own worth and control in establishing life goals, perhaps they would be seeking gratification through other channels of activity." FROM THE PLURALISTIC SOCIETY THE GOVERNOR'S TASK FORCE

b Promote healthy family lives for employees which will benefit the employers through increased productivity and stability of employees.

1. Develop employee wellness programs which offer employees opportunities to learn about sexuality, parenting and communication issues and which provides resources for counseling.
2. Develop family centered events for employees which support employee morale and increase opportunities for family members to experience the work environment.
3. Provide employer-assisted child care in recognition of the importance of parenting and the need for quality child care.
4. Create personnel policies that respond to the needs of parents including options for flex time, job sharing and parental leave for new parents or child emergencies.
5. Encourage employer-sponsored internal communications such as bulletin boards and publications to include health promotion, parent/child communication and family life issues.
6. Utilize consumer relation activities to include messages on health promotion, parent/child communication and family life issues.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the Idea Bank located in the Appendix.

Career Conferences
Child Care Connections
Cooperative Education
L. L. Bean Health and Fitness Program
San Francisco Downtown Plan
Summer Youth Employment Program
Targeted Jobs Program
Unionmutual's Well Power Program
WEET
York County Health Services Grant from Maternal and Child Health—parenting in a work setting

x. what can government do to help prevention of adolescent pregnancy?

The Task Force understands that the causes and problems of adolescent pregnancy are complex, both personal and cultural. No single element of our society can alleviate the problems with one single act. There are many actors with many roles.

Government, too, has a role. The Task Force believes that the State of Maine must assume a position of leadership in policy, planning and program implementation to assist teens in delaying pregnancy and parenting. Government then can serve as facilitator, enabler, funder and planner—all vital aspects of a successful community response to children, adolescents and their families.

The Task Force has decided to address its recommendations directly to state government. It is through state government that federal policies and most federal resources are directed. It is through state government that many community agencies and programs receive public resources. Although most recommendations require action on the part of the executive branch, we thoroughly expect both municipal and county governments and the legislative branch to see their roles and responsibilities and to act on them. We recommend that state government:

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a Facilitate the development of a local, community response to the complex issues involved in adolescent pregnancy by providing leadership, funding and technical assistance to communities. Responsibility: Department of Human Services. (Section III Community)

The community should develop a local action plan which addresses the most effective means to coordinate resources, increase community awareness, identify and establish prevention programs and services for pregnant and parenting teens, develop referral networks, and offer support

to parents of teens. Local action plans should be developed by local action councils who provide leadership and take responsibility for implementing the plan. Councils should include: teenagers, parents, teen parents, educators, clergy, medical and business representatives, service organizations and providers of services. Funding available for this project should include resources for local communities.

For the greatest success communities may want to build on already existing efforts within each community and to recognize shared stategies, shared clients and shared resources among the varied problems families address.

b

Develop funding mechanisms, as needed, to respond to financial requests from local communities to assist them in implementing the local action plans. Responsibility: Department of Human Services (Section III Community)

c

Provide and maintain funding for social services, community services and health/medical services that work towards the prevention of teen pregnancy. Responsibility: Department Human Services. (Section VII Health/Medical and VIII Social Services)

1. Provide funding to maintain longevity among qualified front-line workers thereby increasing their effectiveness with teens.
2. Provide funding to expand primary prevention and early intervention services.

For the purposes of determining funding priorities for pregnancy prevention, recognize that there is a relationship between pregnancy among teens and the personal, health and social problems found in their families. Therefore funds should be made available for programs that provide a stable foundation which help children grow into healthy adults. Such basic family supports include medical assistance, child care, homemaker services, transportation, counseling, income maintenance and others.

d

Fund the development and implementation of a statewide public education campaign utilizing mass communication techniques. Responsibility: Department of Human Services.

1. Promote parenting skills, improve parent-child communication, and support healthy sexuality and responsible sexual behavior. (Sections I Family, II Teens, III Community)
2. Promote the use of social services and health and medical services for teens. (Sections VII Health and Medical, VIII Social Services)

e

Provide funding for community based programs and activities that work towards enhancing parent/child communication, and improving parenting skills. Responsibility: Department of Human Services. (Sections I Family, II Teens, III Community)

Additional State and Federal funds should be made available through the Department of Human Services' contracting process. Technical assistance should be provided to community agencies to encourage the development of private funding sources to augment public funds. The Department of Human Services should work with the Department of Mental Health and Mental Retardation to coordinate the public funding for community based programs receiving funding from both departments.

f Provide funding for school based child care programs which offer experiential learning for students in the care and nurturing of infants and children. Make the service available to teen parents, school personnel and families in the community. Responsibility: Department of Human Services. (Section IV Education)

g Fund programs that help to develop jobs and employment learning opportunities for teenagers. Work with the business community. Responsibility: Department of Labor. (Sections IX Business and Employers, III Community)

h Increase funding for the development of peer counseling and peer support programs statewide. Responsibility: Department of Human Services. (Sections I Family, II Teens, III Community, IV Education)

i Support the development of community programs which offer adults as surrogate models and support persons for teens. Identify paraprofessional and volunteer efforts. Responsibility: The Department of Human Services. (Section I Family, Section III Community)

j Provide funding for local communities which have expressed interest in and begun organizing school-based comprehensive health services. Responsibility: Department of Human Services. (Sections I Family, IV Education, VIII Health/Medical)

This recommendation did not receive approval from certain Task Force members because they do not support school based health clinics. Please see the "Explanation of Minority Votes."

k Assure adequate funding of reproductive health services that offer specialized services for teenagers including counseling about sexual behavior and decison making as well as the use of contraceptives and follow-up counseling regarding their decisions about sexual activity. Responsibility: Department of Human Services. (Section VII Health/Medical)

This recommendation did not receive approval from certain Task Force members because they do not support the use of contraceptives. Please see the "Explanation of Minority Votes."

"I am a 17 year old girl who has a beautiful, healthy, 4 month old son, who is not undernourished or under loved. I quit school BEFORE I became pregnant and I do regret it, but I am going to night school to finish my high school education. We don't have any money, but we've got lots of love, and they say 'love can get you through the hard times with no money, better than money can get you through times with no love.' Whenever I sit there feeding my baby with only a quarter in my pocket I think of this."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

I Assure the adequate training, through increased training programs, of all professionals who work directly with teenagers and their families in the area of adolescent sexuality, pregnancy and parenting. Include paraprofessionals and volunteers. Responsibility: Department of Human Services. (Sections VII Health and Medical, VIII Social Services)

The Task Force believes that a lack of training in the highly specialized skills necessary to impact on teenager's behavior exists among Maine professionals. Increased funding for training and the support of efforts to coordinate and improve training programs will assure more effective programs for adolescents and their families.

m Provide state leadership and, where necessary, state funding to assure training for teachers to properly conduct a comprehensive health education curriculum which includes family life and sexuality education. Responsibility: Department of Educational and Cultural Services and Department of Human Services. (Section IV Education)

n Provide funding to maintain a comprehensive Information and Referral System that is accessible to teens and their families and that includes information on teen health and social services. Build upon existing successful models. Responsibility: Department of Human Services. (Sections VII Health/Medical, VIII Social Services)

o Affirm its commitment to the prevention of teen pregnancy and assume a leadership role in the on-going work:

1. Establish, by Executive Order, a cabinet level council consisting of the Commissioners of Human Services, Labor, Educational and Cultural Services, and Mental Health/Mental Retardation to maintain adolescent pregnancy prevention as a state priority. Provide adequate staff assistance and resources to carry out the work of the Council. Responsibility: Governor's Office.
2. Continue the efforts of the Governor's Task Force on the Prevention of Adolescent Pregnancy and Parenting by developing a council to monitor the implementation of the Task Force recommendations. Members shall include the Task Force leadership, teens and other representatives of state government. This council shall act as advisors to the Cabinet Council on Teen Pregnancy and report the progress of the Task Force work to the previous Task Force members and to the public within one year. Provide assistance and resources to the Task Force council. Responsibility: Department of Human Services.
3. Adopt a long term plan for the utilization of government resources. The plan shall be derived from the Task Force report and highlight the work of Maine communities in assisting teenagers to delay pregnancy and parenting. It should outline the coordination of state, federal and local services. Responsibility: Cabinet Council.

p Convene a statewide group to include representatives of Maine's mass communication media, advertising, business, adolescents, parents, clergy and professionals who work with adolescents to explore ways that the media can offer more positive images of healthy behavior. Responsibility: The Governor's Office. (Section VI Media)

q Improve and expand opportunities for youth to be involved in making decisions about issues of concern to their communities. Appoint adolescents to government task forces, committees, advisory councils or working groups. Responsibility: Governor's Office. (Sections I Family, II Teens, III Community)

r Assume the responsibility of government as an employer to increase the participation of adolescents as government employees and to promote healthy family life for all employees by implementing the recommendations in Section IX, Business and Employers. Responsibility: Governor's Office.

s Sponsor statewide and/or community conferences for parents and their children, policymakers and professionals to establish new policies, and identify effective programs to improve family life, parenting skills and parent/child communication in Maine. Responsibility: Department of Human Services. (Sections I Family, II Teens, III Community)

A special effort should be made to assure the participation of Maine parents and children. The conference should serve both as a public education and community organizing effort to move forward in assuring healthy lives for Maine children and youth.

"The availability of information and the encouragement of discussion and values clarification is not tantamount to encouraging permissiveness and promiscuity. The most sexually active teenagers that I have met in my work (child psychiatry and incarcerated youth) were ironically the very least informed about sexual and contraceptive physiology."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

t Assign a Legislative Committee to review the Maine labor laws which limit the ability of adolescents to acquire meaningful employment. Such barriers include specific restrictions on age, hours, type of work, parental permission for work permits, etc. Responsibility: Legislature. (Sections III Community, IX Business)

u Change the rules and regulations governing certification so that teachers who are responsible for delivering the family life and sexuality education curriculum in public schools receive specific training. Responsibility: Legislature. (Section IV Education)

v Change State Medicaid policy (Chapter 2 of the Maine Medicaid Manual) to allow reimbursement for consultation and education on reproductive health services by non-medical care providers. Responsibility: Department of Human Services. (Section VII Health/Medical)

w Implement certificate of needs standards that will encourage hospital and clinic participation in comprehensive, reproductive health care services for teens. Responsibility: Department of Human Services. (Section VII Health/Medical)

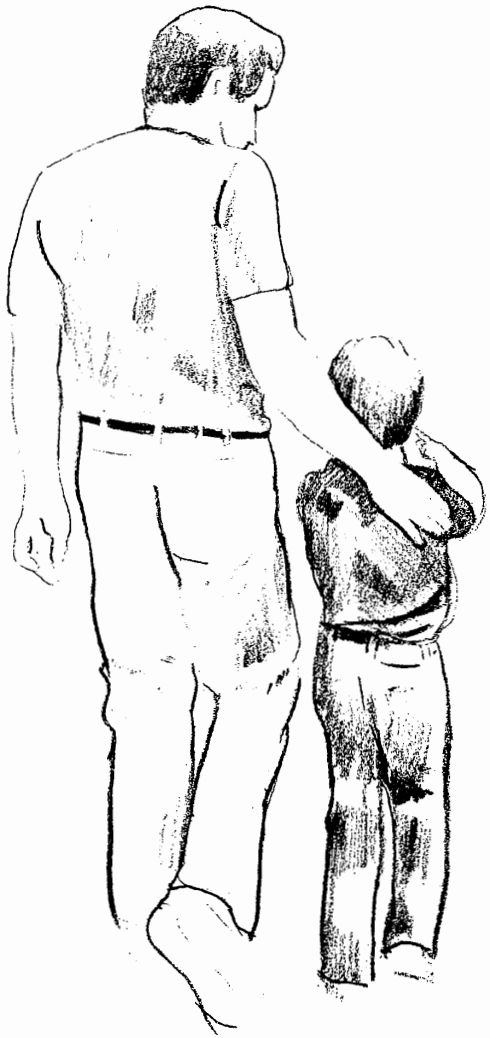
X Take aggressive action to provide leadership, technical assistance and funding to assist the health/medical community to eliminate barriers which interfere with teen's using services. Barriers which the health/medical community may need help in eliminating are: physical accessibility problems because of location of service or lack of transportation, payment of fees and lack of knowledge about services. Responsibility: Department of Human Services. (Section VII Health/Medical)

Y Study Aid to Families with Dependent Children, Medicaid and Food Stamp Programs to identify barriers to self-sufficiency for teens or whether AFDC acts as a "false" incentive to pregnancy. Responsibility: Department of Human Services. (Section VIII Social Services)

Z Advise and assist in a data collection effort which will provide data about adolescent sexual activity in Maine for the purpose of program planning and resource allocation. Responsibility: Department of Human Services.

SPECIAL SUBSECTION ON MALES

ON RAISING BOYS TO PREVENT PREGNANCY AND DELAY PARENTING AS TEENAGERS



The Task Force decided to devote a special section of its report just to MALES. It is our belief that teen males need to become more responsible about their sexual behavior and more involved in decisions about pregnancy and parenting.

But, if we are to effectively transmit this message to males, we must define what we mean by "responsible."

As we have said in "The Pluralistic Society," being responsible does not mean the same thing to each parent or teen. For some, being responsible means that teen boys not put pressure on girls to have sex with them, i.e., to "put out," to "prove her love" for him, or to be "cool." Responsibility may also mean that the boy does not give into the pressures from his friends to be sexually active, nor does he try to live up to the male image of "sexual prowess" or "virility." To others, a responsible male is one who does not have sex outside of marriage and for the male who is sexually active, responsibility means using contraception and preventing pregnancy, not "leaving it up to the girl."

If a pregnancy occurs, most everyone agrees on responsibilities surrounding pregnancy and parenting: The male must become involved in the decisions about the pregnancy, whether to abort or to carry the pregnancy to term. If the decision is to continue the pregnancy, more responsibilities must be faced—whether to choose adoption, whether to continue the couple relationship, or whether to marry. Regardless of his relationship with the baby's mother, if the teen becomes a parent, he must share the health, economic and emotional needs of his child. In short, he must be a responsible father.

For some young men, these expectations may be overwhelming. We may be expecting more of them than they have ever been taught to do, or to be.

SO, HOW CAN WE TEACH RESPONSIBILITY?

Again, opinions differ. Some say that teaching that premarital sex is a sin is the most efficient way to promote sexual responsibility. Others believe that we must confront many societal factors: lack of consensus regarding sexual values, marriage and family life; pressure from a sexually permissive society; and low self-

esteem and lack of direction in the lives of adolescents. Still others blame the lack of information about sex and sexuality and ignorance of the consequences of teen pregnancy and parenting; the lack of access to and proper use of contraceptives; or the lack of a safe, secure family life free of sexual abuse, violence and poverty. The Task Force report, as a whole confronts these issues and makes recommendations to assist teens in developing healthy, responsible behavior.

But as a society committed to the health and well-being of all children, we must address the future and the children of the future. The bottom line is that something must change.

Changes do not occur overnight. We can not expect boys or men to change without fundamental changes in the complex socialization that shapes their lives. We have to challenge the notions of what the male is supposed to be. It will be important to understand how males interact with one another, what expectations they have of loving relationships, how they receive nurturing and emotional support, and how they learn the meaning of masculinity. Finally, with regard to adolescent sexual ideals and male roles, we will have to seek a fundamental change in attitudes, among males as well as females. All of these efforts call for systemic cultural changes in the way we raise boys to become men.

In HOW MEN FEEL: THEIR RESPONSE TO WOMEN'S DEMANDS FOR EQUALITY AND POWER, Anthony Astrachan describes the " new man" as one who is "capable of sensitivity, intimacy and commitment and has transcended most traditional male sex roles and the male attempt to monopolize power." The "New Man" 'supports women's quests for independence and equality with more than lip service.' Based on interviews with men in occupations as diverse as soldier, factory worker and architect, Astrachan discovered that the "new man" does exist, but only 5 to 10 percent of the hype men interviewed come close to the ideal. "He's nowhere near as prevalent as the media has made him out to be."

The Task Force offers the following recommendations to build on the remainder of the report. They are added to the recommmendations on parent/child communication, the moral and educational issues and the messages and values that need to be reinforced in behalf of all teens. They are presented in the context of two basic premises:

1. Females need much of the same kinds of changes in childrearing and socializing as we are suggesting for males. Likewise, many of the recommendations in Part One (Prevention), and Part Two (Parenting) pertain to males as well as females. This special section is designed to emphasize the need for specific, concrete changes in behalf of young men and boys.

2. Childrearing and society's expectations of males are already changing. The change may not be as pervasive as the media "hype" portrays, but the Task Force believes that there are many men and boys who act out responsible sexual behavior, who delay sexual activity, who prevent pregnancy and who are responsible fathers. The stereotypical male is no longer a fair description of all men and boys. These recommendations are meant to suggest ways to reverse what has been years of indoctrination about sexual behavior and sexual mores for males. (The background information is taken from a research document prepared for the Task Force entitled: "Male Sexuality." (Kimball, 1986)

WHAT CAN THE FAMILY DO?

A Provide boys with touches, words, looks and other gestures and expressions of love.

A male's capacity to love is built on the experience of having been loved. His self concept is greatly influenced and powerfully effected by what he learns about feelings of caring, closeness and tenderness for people of the same and other sex—both inside and outside the family. The child's first teachers of love are his parents.

Expressions of love consist of touches, words, looks and other gestures. They convey deep and meaningful affectionate messages to the child. He feels valuable, worthwhile, and prized as a person and family member. These communications become the basic model for a love relationship and have a profound and compelling effect on his emotional development, his self-concept, and later his ability to develop healthy, intimate relationships. "The absence of a loving, involved and present adult in the life of a child leads to emotional deprivation and vulnerability which expresses itself in many ways." (Carrera, 1985)

B Provide males with more physical contact and opportunities to develop emotional intimacy as an experience of caring apart from sexual implications.

"Restricted affectionate behavior" can cause serious emotional problems for some boys and men." (O'Neil)

The lack of touching in males begins early, in some families as early as two years old. Often one of the first persons to limit their touching is the boy's father, followed by other male models such as grandfathers or uncles. While girls are cuddled, boys are patted on the head. Later, when girls are still hugged and kissed by their fathers, boys are expected to shake hands, the firmer, the better.

Boys are rarely taught intimacy at home or in school. Physical contact is often restricted to tough contact—congratulatory slapping in sports; punching, tackling, or blocking. Only recently has hugging between men started to surface as acceptable, but contact is still minimal and relegated to athletic congratulations. Male's physical contact with women is more acceptable than with each other but often has undertones of sexual activity—it is seen as one step towards intercourse.

The impulse for emotional intimacy inevitably brings with it the desire for sexual expression and can encourage sexual behavior. Boys grow up, not "sex starved," but "touch hungry." Too often the only touch that is acceptable is "scoring" with females. (Rhoades, 1986)

C Assist boys in their identity struggle.

During adolescence, a boy experiences growth spurts created by increased hormonal production, and puberty. In addition to the physical changes, a boy learns how to be a man, how to like himself, how to understand his sexuality and how to develop relationships. He begins to discover what he wants in a potential partner and what others like about him.

He is also concerned about his sex role identity—he wonders if his behaviors, interests, and attitudes are consistent with masculine norms.

Historically, the primary caregiver in any child's life is the mother. Therefore, young girls establishing their gender identity have a definite role model very present in their lives. The boy, on the other hand, must reject his caregiver as role model, and in the process, may reject most traits he perceives as feminine. He must unlearn those behaviors he has learned; he must learn who he is not, rather than who he is. Boys sometimes discard a whole range of behaviors: intimacy, touching, expressing feelings, showing vulnerability, passivity and others. (Thompson, 1986) Anything vaguely resembling feminine behavior often gets labeled "effeminate" or "homosexual." This fear, or homophobia, is one of the most powerful social and personal forces governing adolescent males. (O'Neil) They often resort to exaggerated toughness, sexual aggression, and risk-taking to prove their virility and masculinity; they may seek early sexual relationships for such fulfillment.

D Provide healthy, positive male role models.

In his first years, much of a boy's learning about masculinity comes from the influence of his parents, siblings and the media.

The father as male role model shapes the son's self image. Boys especially need to hear from men who can explore and express their feelings, and who show a caring, vulnerable side. Many fathers are absent much of the time from their sons' daily lives. One study shows that fathers interact with their infant children on an average of 37.7 minutes per day. (Swetnam) Other studies show a much lower figure. In some families, fathers may never see their sons. There are few males in society in positions such as school teachers or coaches who can be a model of sensitivity and caring. In the absence of adult role models, young boys will model after older boys where virility is equated with the quantity of sexual conquests.

E Provide boys with opportunities to learn healthy competition and that sexual behavior is not a contest.

Boys often view themselves in relationship to, and competition with other boys. This process is not nurturing or cooperative, but takes the form: Am I his superior? Is he my superior? In order to gain ascendancy over others, males are often taught to expend lots of energy on the manipulation of power. (O'Neil)

The young boy learns to hide his fears and share his anxieties with few, if any, of his friends. He learns quickly that he is to report only on his conquests to his male peers. A male teen tends to believe that sexual performance not only proves his manhood, but also gives him status with male peer groups.

F Provide males with outlets to express emotions and relieve tensions.

Boys learn to keep a tight control on their emotions—"it is the male thing to do." Besides sports, in which very few boys excel, they have few noncompetitive outlets to relieve tensions. Rarely are the theater, creative writing, art or debating viewed as outlets for tensions and emotions for boys. Males of all ages have a limited vocabulary of feelings. In counseling, they are inclined to respond to the questions "How do you feel?" with "I think." Males also fall victim to many more stress-related diseases than do females. (O'Neil) Pressure to achieve and perform are more powerful than encouragement and support to take care of himself. (Erickson) Researchers suggest these stress factors contribute to reasons why boys, much more often than girls, demonstrate antisocial, destructive and self-destructive behavior.

G Provide information on sex and sexuality to boys, and improve communication between father and son.

Boys are even less likely than girls to have reliable sources of information. They often rely on "street" knowledge. Where mothers are apt to discuss sexuality with daughters at the onset of menstruation, fathers do not take the same opportunity with boys. There are many reasons: (1) embarrassment on the part of the father, (2) absence of the father from the home, (3) lack of knowledge on the part of the parents, (4) the belief that consequences of teenage pregnancy affect males much less than females, and (5) the proliferation of "manly" attitudes that sexual activity is a male conquest. Often without communication boys try to live up to the stereotype that when it comes to sex, "they know it all."

Boys need to learn to discuss their concerns with a trusted, informed adult, and to ask for help, information and support when they need it.

Studies show that where parents are the main source of sex education and where there is a positive identification with parents, first coital experiences (sexual intercourse) occur at later ages, and contraceptives are used more frequently. But since boys receive little parental instructions; what they receive instead is a double standard with regard to sons and daughters, i.e., that sex is more permissible for sons than for daughters.

H Help boys understand that there are consequences to risk-taking and to accept equal rights and responsibilites for their sexual decisions.

Teen boys, especially those sexually experienced, appear to be more risk-taking than females. (Moore and Burt, 1982) They do not perceive that an early child-birth will limit their educational and occupational attainment. Their decision to have sex is often confusing and

unplanned, rather than a considered decision about whether this is the right time in either's person's life to be involved sexually.

Adolescent boys need to clarify their values and goals, understand social and economic consequences of early parenthood, and develop decision-making skills. They must understand that sex involves intimacy, feelings, responsibility, and values. They need to be responsible either for contraception or for saying no. A teen boy has the right to help decide what to do if his girlfriend gets pregnant. And most importantly, if he becomes a father he has the right and the responsibility to share in the economic, health, educational and emotional needs of his child.

I Help boys adapt to new and changing sex roles.

Although sex roles are changing, boys are still socialized with the expectation that they will be held responsible for "solving life's problems." Men are identified in our culture by their work. Their drive to achieve is set at a very early age through sports, in school, and by traditional male role modeling. Males often become more goal-oriented than females and more linear in their pursuits. (O'Neil) It is not surprising then that boys tend to perceive sex as an acheivement. Note the vocabulary—"Did you score?" or "Did you get anything?"

As women have progressed in equality in the last twenty years, men have not been as successful at liberating themselves from stereotypical sex roles. Those traits which define traditional masculinity are the same traits which make it nearly impossible for males to challenge the tightly defined roles they grow into.

With changing sex roles, boys and girls are often confused about their relationships. Boys are now adjusting to new relationships with girls who often plan to be independent, autonomous, and competent. A boy's sense of masculinity now needs to shift from other than the perceived female's dependency on him.

Research on male attitudes has shown that many men are beginning to express positive feelings about change in women's roles, "ranging from pride, admiration, identification and pleasure, to relief, as when a wife's higher salary helps to pay the bills." Others express support and acceptance for women's attempts to achieve equality. (Astrachan, 1986)

In studies, males who were more egalitarian in their outlook were better at preventing pregnancy. (Rhoades, 1986) Men and boys need to continue examining their roles in society and to challenge them.

WHAT CAN THE EDUCATIONAL SYSTEM DO?

A Require boys to participate in community developed and supported educational programs which include information about sexuality, contraception, communication and decision-making skills, and family responsibilities.

Boys have even more limited information about sexuality and contraception than girls. Most boys do not discuss sexual activity with their partners before intercourse. They expect the girl to be responsible either for contraception or for saying no. The decision to have sex is often confused and unplanned for teens, rather than a mutual decision between responsible partners.

B Provide programs and set examples that teach and reinforce the view that females are individuals with equal rights and dignity.

Boys must learn that every girl is a person in her own right with a dignity of her own, which he must learn to appreciate and respect. He needs to turn his attention to the possibility of interpersonal satisfactions other than sex, and to regard sex as only one component in a more inclusive relationship.

Schools need to emphasize male/female-integrated activities and equal opportunity such as cheerleading, sports, and leadership organizations. School personnel and administration should model equality of the sexes.

C Provide healthy experiences in conflict resolution and cooperation.

"School athletics are a microcosm of the socialization of traditional male values. It often becomes a lesson in the need for boys to be tough, invulnerable and dominant. While encouraging traditional male values, schools provide few lessons in nurturance, cooperation, negotiation, and nonviolent conflict resolutions. Nor do they provide strategies for learning to empathize with and empower others. Schools have to be places where boys have the opportunity to learn these skills; for clearly, they won't learn them on the street, from their peers or on television." (Carrera, 1985)

WHAT CAN THE MEDIA DO?

A Promote positive aspects of male sexuality, new male models, the delaying of sexual activity, and the importance of avoiding pregnancy.

Children are bombarded by sexual stimuli—in magazine ads, on commercials, in television shows and movies, in novels. . . Yet, almost nothing that young men hear or see about sex from the media informs them about the importance of avoiding pregnancy or being responsible in their sexual decisions.

We need to foster sexuality as a positive, dignified aspect of life, and to help build awareness that sexuality involves emotions, caring and sensitivity. We need media examples of adult males as nurturing, caring people; of teen males in caring relationships with peers.

In an NBC interview with perpetrators of domestic violence, several men talked about the media's message to them about male violence: There are all kinds of pressures to be a "breadwinner," to be better than the next guy, to be the good guy and save the day, but when the bad guy beats up the good guy in the beginning of the show, and by the end of the show the good guy beats up the bad guy and wins . . . that tells me that violence—if you're the good guy—is okay.

Media could offer images that help boys learn to accept their vulnerability; to express a range of emotions including fear and sadness; to ask for help and support when they need to. They could learn to be gentle, nurturant, cooperative and communicative. In particular, they could learn nonviolent ways to resolve conflicts. Boys could be permitted and encouraged to cry, be afraid, show joy and express love in a gentle way. (Thompson, 1986)

WHAT CAN THE HEALTH AND MEDICAL SYSTEM, THE SOCIAL SERVICES COMMUNITY AND GOVERNMENT DO:

A Conduct more research in male contraceptive knowledge, attitudes and practices.

Most boys do not know how to use contraceptives properly and do not know whom to ask for that information. Nor, do boys have the vocabulary to initiate such a dialogue. Often they don't know how to say "no" to sexual activity.

B Provide programs for males that offer access to free or low cost medical examinations, sexuality and male role counseling, and contraceptives. Involve male partners, when appropriate, in discussions about contraception and pregnancy options in programs that serve females.

Maine lacks specialized services designed to respond to the specific needs and characteristics of males. One program, "Males Place" in Charlotte, North Carolina, offers free examination, sexuality counseling and contraceptives located within easy access to males.

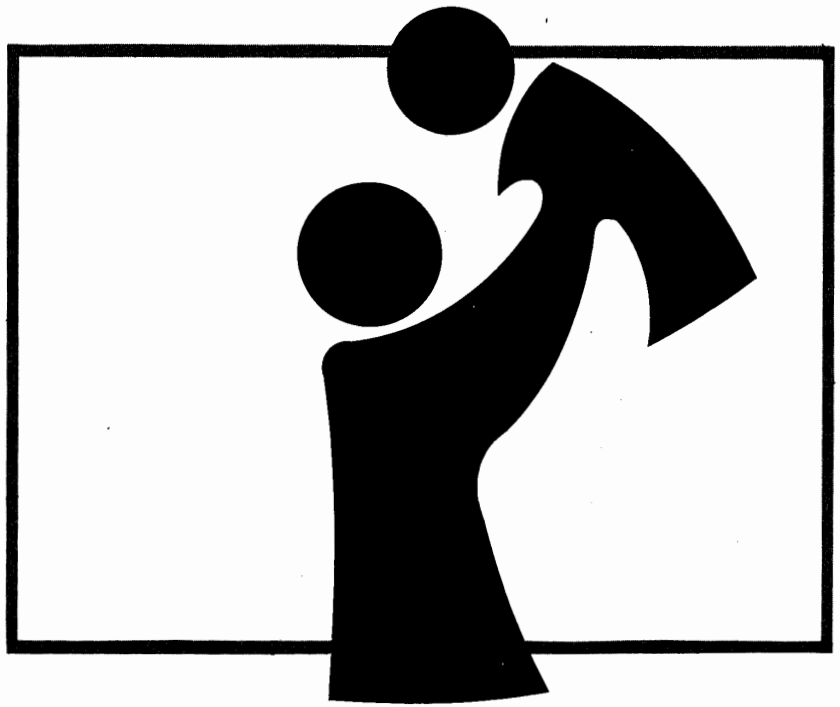
Providers of services in Maine can assist boys by initiating conversations with them on otherwise sensitive subjects such as their feelings, fears and sexual decisions.

C Provide education and training for people working with males, challenging the notion of what the male is supposed to be.

Masculinity includes the ability to nurture, provide emotional support, communicate openly about sexual concerns, and become more involved as fathers. Personnel need to learn new ways to interact with males that will reinforce healthy, responsible decision-making.

PART TWO:

strategies to minimize the adverse effects of adolescent pregnancy and teenage parenthood



introduction

The previous section of recommendations has addressed strategies for the prevention of adolescent pregnancy. However, every year over 3,000 teenagers in Maine become pregnant. This second section of recommendations addresses the needs of those adolescents. Of the 3,000 teen pregnancies each year the majority of young women, more than 2,000, make the decision to carry their pregnancy to term and to become parents. Approximately 1,060 teens will be faced with the new and challenging responsibilities of being a single parent. A smaller number of teens, approximately 970, will be married or choose to marry by the time the baby is born and then enter this new phase of life with both parenting and marital responsibilities. These two groups of teens have similar needs for support and assistance. A third outcome of teen pregnancy, approximately 1,150 per year, is induced abortion. This choice is the most frequent outcome for the younger pregnant teen and abortion is chosen by them 3 times more often than for adult women. The fourth outcome for pregnant teens is to choose adoption. Adoption is also a sensitive topic subject to large shifts in its popularity and acceptance. In recent years less than 80 teens per year choose this option.

The Task Force, as a whole, is neither able nor willing to recommend one outcome of pregnancy over another. Regardless of our personal, moral or political views, each choice of a pregnancy outcome has benefits and liabilities for the individual. We recommend that all pregnant and parenting teens recieve proper support and guidance for all their decisions. The recommendations address each of the four outcomes of pregnancy in the order of frequency with which they are chosen: parenting, both single and married, abortion and adoption.

i. what can families do for pregnant and parenting teens?

a Foster good communication within the family to establish an environment in which it is safe for your daughter to tell you if she is pregnant, or for your son to tell you if his girlfriend is pregnant.

b Make certain that your daughter receives immediate medical attention both for pregnancy verification and for early prenatal care to assure a healthy pregnancy.

c Provide a supportive, loving home for your pregnant teenager and/or teen mother and her child. Remember that your son needs support too.

Some teens report that their families are so traumatized by the pregnancy that they must leave the family home and independently face the major problems of where to live and how to support themselves.

d Encourage your teenager to participate in counseling services during and after pregnancy to assist with: options explanation, peer support, self-esteem, parenting skills and relationship or pre and post marriage counseling.

e Advocate for your teenager's continued schooling, return to school, or alternative program for continued education and preparation for her or his future.

Your daughter is eligible for a special education program provided by your school system during her pregnancy. The goal of the program is to maintain her academic preparation and prevent her from dropping out of school.

f Work with your daughter to involve the child's father in pregnancy decisions as well as the support and future planning for the child.

In many situations the father, especially if he is a teenager, will become isolated from the pregnancy and his parenting role due to the emotions felt by everyone involved in the pregnancy. In other situations it may be difficult or even inappropriate to involve the father. Both you and your daughter need to become aware of the father's legal rights and responsibilities.

g Provide economic support within your capabilities for your pregnant or parenting daughter; seek out government assistance for her and her baby if your family funds are not capable of supporting them and meeting medical and other expenses.

Such programs that may be available to your daughter are AFDC, General Assistance, Food Stamps, Medicaid, W.I.C., Prenatal Care Program, job training, subsidized child care and housing assistance. Although limited, combining these resources can assist your family in remaining together and developing healthy children.

h Encourage your son to meet his financial obligations for his child and assist him in developing an appropriate parenting relationship.

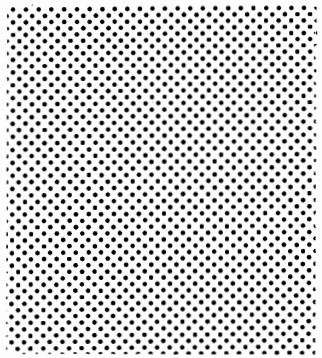
i Recognize that although your teenager may be about to become a parent, he or she remains an adolescent with the same developmental needs as before the pregnancy. Help your teenager in re-entering adolescence.

One of the most difficult tasks for teens who have faced a pregnancy or have become parents is completing their normal developmental tasks. Despite the changes that have occurred, teens need to finish growing up in order to meet the inevitable demands of adulthood.

j Help your teenager learn to become a good parent; find parenting classes or programs providing child care instruction for her or him.

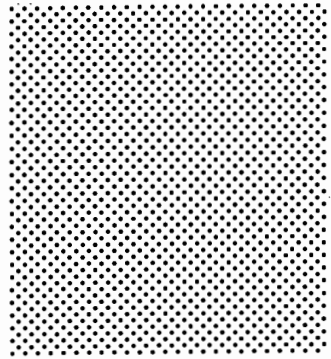
k Help your daughter or son prevent subsequent unintended pregnancies by encouraging an appropriate pregnancy prevention plan such as delaying continued sexual activity or using effective contraception.

This recommendation did not receive approval from certain Task Force members who do not support the use of contraception. Please see "Explanation of Minority Votes."



The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

BIRTHLINE
Bonney Eagle High School Peer's Group
DuSable High School Health Clinic
Family Planning—Clinic System
Family Services Program
Genesis
Maine Children's Home
Male Adolescent Program
Parenting Education through Headstart
Parenting with Pat
Parent Resource Center and the Parent Connection
Parent Support Groups (See Diocesan Human Relations Services)
Portland Teen Health Program
Portland YWCA Teen Parent Services
St. Andre's
School Based Health Clinics
Somerset Adolescent Pregnancy Project
YWCA Intervention Program



ii. what teens can do who are pregnant or parenting

a For pregnant teens at all stages of decision making regardless of the outcome of their decisions you should:

1. Obtain a pregnancy test as soon as possible from an agency or health professional who will provide non-directive comprehensive pregnancy options counseling and reassurance.

   You can use the yellow pages of your telephone book to locate a pregnancy testing service. It is important to ask them if they emphasize a particular service such as abortion, adoption, or unbiased options counseling. Choose one that is right for you.
2. You, both males and females, should discuss these decisions with your parents, or other significant adults. Because of the feelings and values involved, it is important to have their support for your decision.
3. Both males and females involved in a teen pregnancy need to talk to an adult (parent, teacher, doctor, school nurse, clergy, counselor or other relative) who can listen, assist you and suggest an appropriate agency or health professional for counseling or for health care services.
4. Obtain immediate and ongoing medical attention.

   No matter what choice you make about your pregnancy, you need to get medical care in the first one or two months of pregnancy. If you decide to continue your pregnancy, early prenatal care can help prevent medical problems from developing.
5. Learn about and use the help that is available from peers and family as well as from counseling programs, social service agencies and clergy. Use these services with the following goals in mind:

   a. facing the reality of the pregnancy and that being pregnant does not change your self-worth;

   b. making rational decisions about your pregnancy or your parenting responsibilities which should include a balanced, well-informed view of your pregnancy options: parenthood (either as a single or married parent), abortion, adoption;

   c. sharing your thoughts and fears to overcome the feelings of isolation; and

   d. receiving counseling assistance after your decisions about the pregnancy have been made.

   Each outcome of your pregnancy will have certain benefits and liabilities. It is important for your own continued growth to resolve feelings of fear, confusion, guilt or doubt and to overcome frustration and isolation.
6. Involve the father in the decision making process.

   When possible, involve the father in discussions about your options and your decisions. You may choose not to involve him because in some situations this may be difficult or even inappropriate. Remember that he may have both legal rights and responsibilities for a child once it is born. He may be required to make child support payments. He may also request custody or visitation. If you choose adoption for your child the court may require his agreement to finalize the legal adoption.
7. Prevent further unintended pregnancies by either delaying further sexual activity or using effective contraception.

b For pregnant teens who choose to parent their child; the following recommendations are made in addition to the ones in Section A above.

1. Obtain good health care throughout your pregnancy and following the birth.

   Your baby's health is effected by the things you do, smoke, eat and the way you feel. You need prenatal medical care, vitamins and advice about your diet to prevent serious problems for you and your baby.
2. Prepare for the transition to motherhood or fatherhood by participating in:

   a. preparation for childbirth classes;

   b. parenting skills education;

   c. counseling and education about life decisions, such as where to live, budgeting and financial

support, how to continue education, what will be needed for the baby;

d. programs that provide peer support with other pregnant and parenting teens.

3. Obtain additional help if you intend to marry or continue a relationship with the father or mother of your baby in order to carefully consider this decision.

   Pregnancy itself may not be a reason to marry. Consider using services for learning about conflict resolution, communication skills, pre-marital and relationship counseling, parenting classes or peer groups which would support your relationship.

4. Contact an attorney or the child support enforcement unit at the Department of Human Services to obtain help in getting the father to accept his financial responsibilities or to acknowledge paternity.

   There are tests available to assist you in proving the identity of the baby's father. But first you need to talk to professionals prepared to help you.

5. Understand that the services of adoption agencies are still available to you after the birth of your child. Contact them if you would like to explore that option.

C

For pregnant teens choosing abortion, the following recommendations are made in addition to those in Section A above:

1. Obtain information and counseling about abortion as soon as you know you are pregnant if you want to consider this option. Involve your parents and/or boyfriend in this decision whenever possible.
2. Understand that abortion is a medically safe procedure and legal.

   Since people have strong moral convictions, either for or against abortion as a pregnancy option, it may be difficult for you to decide for yourself whether this is a choice you want to make. Be sure you make the decision based on facts and your own moral values.

   This recommendation did not receive approval from certain Task Force members who do not support abortion. Please see the "Explanation of Minority Votes."

3. Obtain follow-up counseling and emotional support to resolve feelings of grief, guilt or other feelings which are sometimes part of the experience.

d

For pregnant teens who choose adoption the following recommendations are made in addition to those in Section A above:

1. Obtain good pre-natal care throughout the pregnancy.
2. Investigate an open adoption process which will recognize and be sensitive to the needs of all the individuals involved in the adoption—you, your baby and the adoptive parents.
3. Understand choosing adoption for your child can be a good and loving option. It may be a way to provide a better life for your child than you can currently offer.
4. Understand that this option is available throughout the pregnancy, and after delivery. Both the mother and father and their families can receive counseling and information about adoption.
5. Beware of "black market" adoptions or individual adoption arrangements that are made without the help of either an attorney or public or private adoption agency.

   Public and private adoption agencies are licensed by the state to insure that your legal rights are protected. Those agencies also have standards for interviewing adoptive parents to help you influence the choice of the best possible parents for your child.

6. Obtain follow-up counseling and emotional support to resolve feelings of grief, guilt or other feelings which are sometimes part of the experience.

teen questions

Teens recognize their need for sex education and information, and they want help from adults in understanding their sexuality, developing values and setting goals and limits. These questions were among those asked by 400 teens who attended "The 1986 Teen Conference" held in Bangor, Maine. The group of 12-16 year olds were offered the opportunity to ask questions anonymously. The questions are grouped here according to three major components of family life and sexuality education curriculum: (1) adequate and accurate knowledge learning about family life and sexuality; (2) clarification of attitudes and values; (3) developing skills in decision making and communication.

knowledge

What is sex? Why do I get sexually aroused?

How come boys don't have their periods?

How many birth controls are there?

Are women supposed to have sexual intercourse when they're having their periods or when they're not?

Why does it take so long for some people to start to grow? Especially me?

When a boy ejaculates not inside you, but you are both naked, can you get pregnant?

Can you get AIDS by having heterosexual sex?

What is considered rape?

At what age do you get orgasms?

Is sex healthy?

attitudes and values

Why do people think sex is such a big deal?

Is sex a thing you do for fun or because it's something you just have to do?

Why are our schools not more open about sex and try to make students more aware of the real pros and cons of it all?

Why are our parents so worried about their children getting involved with someone at our age?

Why is it so bad when you do it with somebody you are a sleaze, when you don't you are a lesbian, and if you go halfway with them you are a tease?

Why do girls get called sluts if they have sex but it's all right for the guy?

Do you think you should always know the boy good before you have sex with him?

If you are careful and take precautions, and you really are in love, what's wrong with having sex?

Why should I feel stupid just because I haven't kissed a boy and my best friend has? I'm just not as aggressive as her.

What is life because I really don't understand it?

skills in communication and decision-making

How do you tell a guy you don't want to have sex?

Why do some boys fight with girls or say they hate them when they really like them?

How can I make my relationship with my boyfriend better?

How do I talk with my mother about my sexual feelings?

What should you do if you get pregnant and you don't want your parents to know?

How do I know if he loves me?

How do you know if a girl wants to have sex with you?

Why are parents always against your decisions?

How do you tell your parents you want to go on the pill because of your relationship with your boyfriend?

How to be "cool" without going along with the crowd and giving in?

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

BIRTHLINE
Bonney Eagle High School's Peer Group
DuSable High School Health Clinic
Family Planning—Clinic
Family Services Program
Genesis
Good Samaritan
Lamaze (Parenthood Education Association's Childbirth Education Classes)
Maine Children's Home
Medical Model Program
Parenting Education through Headstart
Parenting with Pat
Parent Resource Center and the Parent Connection
Parent Support Groups (See Diocesan Human Relations Services)
Portland Teen Health Program
Portland YWCA Teen Parent Services
St. Andre's
School Based Health Clinics
Somerset Adolescent Pregnancy Project
YWCA Intervention Program

iii. what can the community do for pregnant and parenting teens?

a Provide caring and loving homes for teenagers who are pregnant, and for parenting teenagers with their children.

b Seek to eliminate housing problems that teen parents and their children experience in trying to find independent housing. Issues that need to be addressed in each community are: discrimination, availability, affordability, zoning and the development of housing alternatives for teen parents.

c Develop community volunteer programs which provide part-time support persons to the pregnant teenager and teen parent.

Often teens need supportive adults other than their parents to offer emotional support, information and assistance. Volunteers or professionals who are trained and available to respond to teen parents can promote healthy parenting.

d Assure better entry for the pregnant teen and teen parent and his or her family into health, medical and social services at the earliest possible moment so that health, economic, social and emotional needs can be met.

Among the most vital services needed at the time of pregnancy and parenting are:

1. Non-directive comprehensive pregnancy options counseling, individual or family counseling and adoption assistance.
2. Medical examination and pregnancy verification, early pre-natal care, nutrition counseling, diet supplements or abortion services.
3. Emergency housing, continued education, employment, job training, financial assistance (AFDC, Food Stamps, W.I.C., medical assistance), child care and parenting education and transportation.

e Actively encourage business and industry to help meet the child care needs of their employees.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

Believer's Fellowship Church
Big Brother/Big Sister Programs
Community Women
Fair Harbor
Genesis
Portland Foster Grandparents
St. Andre's
St. Elizabeth's Child Care Services
San Francisco Downtown Plan

iv. what can the educational system do for pregnant or parenting teens?

a Make available a primary contact person in the school who is trained to assist pregnant teens and teen parents. Teens need to be linked to other services for their health, economic and emotional well being.

All professional school employees should be receptive to listening to a pregnant teen. Teens will speak only to someone they trust, someone non-threatening, someone who they believe will help. There should, however, be a primary contact person for staff to consult. Possible personnel would be a school nurse, a guidance counselor, or the director of special education. The name of this contact person should be made available to both staff and students. The main functions of the contact person would be to help the student to continue her education and to show where help can be obtained.

b Develop policies which keep the student in school during her pregnancy, offer alternative education and encourage re-entry into the school after delivery.

c Utilize the special education process and funding to provide the maximum of continued education activities during the pre and post-natal periods until the student can return to school.

"Dear Dad,
All through the years I grew up I thought if I was to be a good daughter I had to give you something! I felt I had to repay you for adopting me!... I lost one set of parents when I was 3 years old and I lost set 2 of parents when I was 8 years old! ...that's when the abuse started and I lost you as a father but, I gained you as a lover!... I'm 18 years old now and... I have a little baby on the way and I'll never have my kid treated the way YOU treated me."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

d Offer special tutoring or alternative programs to teen parents who are unable to achieve or are at risk for academic failure or dropping out of school

e Include parenting education in the comprehensive health education curriculum. (See PREVENTION Section, IV-Education, A)

f Support the development of school-based child care programs (See PREVENTION Section, IV-Education, H)

The purpose of the program is to (a) encourage teen parents to stay in school, (b) prepare all students for parenthood and (c) provide a vocational training opportunity for students interested in a career in child development. Understand that one component of a school based child care program is to provide transportation for the

infant with the teen mother on regular school transportation. This will require that vehicles be adapted to provide appropriate child seat belts and safety seats for the children of teen parents.

g Develop school-sponsored peer support programs which offer teen parents counseling, emotional support and tutoring as well as an opportunity to influence other teenagers to postpone sexual activity, pregnancy, and childbearing until adulthood.

h Offer reasonable flexibility to teen parents. Although they need to re-enter the mainstream of academic life, they are set apart from other students by their responsibility to become good parents.

i Aggressively encourage teen parents to go to college and vocational schools by providing financial aid, independent study, alternative education programs, and child care.

"Chastity is the only answer. (It) was one sure method of birth control throughout the history of civilization. Only 25 years ago did the sexual revolutionaries develop a different approach. They've had the opportunity to prove their permissive methods and the victims of its failure litter the cultural and medical landscape."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

j Promote vocational training, education and exposure to career paths for teen parents to encourage their transition to the world of work.

k Participate in a special project with the Department of Human Services, Department of Educational and Cultural Services and local schools to assist teen fathers who are minors in meeting both their educational goals and their financial obligation to their child. (Please see Parenting Section: X Government, J.)

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

Bonney Eagle High School's Peer Group; Day Care and Parenting
Brunswick High School Teen Forum
Day Care Practicum at Hampden Academy
DuSable High School's Health Clinic
Good Samaritan
Living Skills Development Course
Maine Children's Home
Oh Boy! Babies!
Peer Support Group at Bangor High School
Portland Teen Health Program
Portland YWCA Teen Parent Services
Project Responsibility
YWCA Intervention Program—Peer Counseling

v. what the clergy can do.

a Increase the efforts to make known the basic religious proposition that all persons have worth in and of themselves.

b Promote attitudes of caring and support for young women, young men, and their families when faced with pregnancy.

c Support those state and community organizations working to assist teens and their families facing adolescent pregnancies.

> ***"I have clients who are born-again Christians and I have clients who profess no belief; clients who are from college-educated parents and clients from parents who never completed junior high; clients who have parents and clients who do not."***
>
> FROM THE PLURALISTIC SOCIETY
> THE GOVERNOR'S TASK FORCE

d Further the work of social justice throughout Maine communities and government in an effort to eliminate the milieu of poverty, despair, domestic violence, child abuse that affect teens and their families.

e Develop and teach programs within your faith group to strengthen family life.

1. Teach the meaning and value of sex and sexuality as it relates to personal growth and development.
2. Prepare couples for marriage, including sex.
3. Provide ways of maintaining and continuing strong marriage relationships, including sex and its role in marriage.
4. Offer clear messages of support and affirmation for family life and marriage at a time when society is questioning the values and meaning of marriage.

f Provide support for teen parents as the primary educators of their children in life values including sex education. Provide programs to help teen parents learn good communication skills and sex education.

g Invite the participation of current and former teen parents in the development and implementation of strategies to address family life and sexuality issues.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

Believer's Fellowship Church
Marriage Communication Laboratory

vi. what can the media do for pregnant and parenting teens?

a Promote a positive image which challenges teens to be good parents but at the same time does not influence other teens to view pregnancy and parenting as desirable teen roles.

Teens who are facing pregnancy and parenting need positive reinforcement, support and confidence. They need to know that there is not something wrong with them and that the messages to help them are not judgmental to their behavior. This is difficult, considering our desire to discourage early sexual activity, pregnancy and teen parenting.

b Help teenage parents be the best possible parents by:

1. Informing teens of resources that can help them consider the decisions about their pregnancy and their options for their future.
2. Encouraging the community to develop programs and services for teen parents such as alternative housing, surrogate families, respite care and others.

c Influence pregnant teens and teen parents to postpone another pregnancy until they are better able to be responsible parents and provide for their children.

d Focus on positive roles for fatherhood specifically designed for teen fathers and partners of teen mothers.

e Improve the community's understanding of adoption.

f Educate the community about pregnant and parenting teens in order to eliminate negative stereotyping.

"I wanted to get pregnant. Everyone I ever loved left me: my dad left, my grandmother died. Now I'm pregnant and I know there's someone who won't leave me until he's at least 18. We're going to have each other and love each other."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

vii. what can the health/medical community do to assist pregnant and parenting teens?

a Insure the availability of health services to pregnant and parenting teens by locating multiple services in one location.

1. Provide comprehensive, reproductive health care services.
2. Provide pregnancy testing with referral to non-directive comprehensive pregnancy options counseling when the pregnancy test is positive.
3. Provide pre and post natal care.
4. Provide pediatric care.
5. Provide medical follow-up and referral to counseling to prevent future unintended pregnancies.

b Increase teen's use of services by locating them in places accessible and familiar to teens, such as schools and at programs that are serving pregnant and parenting teens, and by providing flexible hours of services.

c Insure that health programs for teen mothers are staffed by medical and other professional care givers who are trained and sensitized to specific needs of teens: communication, needs for immediate response to their concerns, sexual abuse, adolescent development, involving teen's family and rights of confidentiality. This training should occur before employment as well as periodically in-service.

Pregnant and parenting teens are on a threshold of adulthood. They are often mistakenly treated as children when their rights of control over their services are ignored. These teens need to be respectfully welcomed into the adult health care environment with the understanding that the quality of their lives and the lives of their children are dependent on this relationship.

d Participate in training for health care providers which offers skills and resources to enable comprehensive referrals for pregnant and parenting teens to other services and individuals who can assist them.

Physicians have reported feeling frustrated by a lack of knowledge for comprehensive referrals and isolated from other appropriate service providers. Teen parents have a very wide range of needs that come to the attention of medical care providers such as the need for parenting or nutritional help.

e Provide opportunities for teen parents to participate on policy making groups of the health service, program or clinic.

f Assure that teens have no financial barriers to quality health care by examining both private insurance and public medical assistance policies.

The high costs of health/medical services to a patient who is uninsured discourage the use of services. Teen parents often require longer medical appointments than the general

population which increases the cost of their services. Although there are limited data currently available about the number of pregnant teens who are inadequately insured by either a public or private policy, the Task Force believes that limited financial assistance for working poor families may prohibit teens from seeking adequate maternity and neo-natal care.

1. Improve medical assistance.

   a. Publicize the current programs which help pay for prenatal care and birth costs in order to improve public awareness and to improve inter-program referrals.

   Problems persist because the programs are not well known, program guidelines are complex and difficult to explain and referrals from one program to another are minimal.

   b. Support the creation of a payment category for teen consultation and education with all professional levels of medical/health care providers in order to encourage more thorough consultation and education services.

   c. Encourage the development of State Medicaid policies that offer incentives to providers to improve services to the adolescent patient.

   d. Examine and advocate for changes in the Federal Medicaid eligibility criteria to encourage self-sufficiency by creating "bridge or stepdown" coverage for teen mothers who are working. These "bridges" need to be of longer duration than for adults to reflect the teenager's need for more assistance in becoming self-sufficient.

   Many teen mothers are discouraged from marriage and employment because the added minimal income would place them above medical assistance guidelines.

   e. Assure that teen women who choose adoption for their child have equal access to the financial assistance programs that help pay for pre-natal and birth costs.

2. Insure that private insurance regulations, and procedures represent the needs of pregnant and parenting teens.

   a. Develop policies which include a provision for all females in a household to be covered by the maternity benefits in order to assist the pregnant teen who remains dependent on her family.

   b. Provide for policies which allow transfer of a pregnant patient to another policy without the barrier of pregnancy as a pre-existing condition in order to assist teens who wish to marry.

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g Implement a public education campaign to insure that the health risks of teen pregnancy are fully understood by teens and by caregivers such as doctors, nurses, midwives, counselors and family members,

There are higher health risks for a young teen mother and her infant than for other age mothers. It is imperative for both mother and child to receive adequate pre-natal, post-natal and comprehensive pediatric care. One barrier to teen mothers receiving this medical treatment is a lack of understanding, both with the general public and with the many care providers, of the risks, associated with early pregnancy and childbirth.

---

h Participate in the development of a network among Maine's health and medical, social service and school community for teenagers who are pregnant and parenting by creating a system of referral to services.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

AHEC (Area Health Education Center) Grant
Div. of Maternal and Child Health Public Education Efforts
Maine Child and Family Learning Center
Maine Pre-Natal Care Program (See Division of Maternal/Child Health)
Medical Model Programs
Portland Teen Health Program
Portland YWCA Teen Parent Services
Project PEDS
School Based Health Clinics
YWCA Teen Parent Services

viii. what can the social services community do to assist the pregnant and parenting teen?

a Initiate an assertive effort to assist pregnant teens with decisions about unintended pregnancies beginning immediately after a positive pregnancy test.

1. Develop programs for non-directive comprehensive pregnancy options counseling for teens on a statewide basis to assist teens with the many personal choices.
2. Develop and utilize referral mechanisms to refer teens to non-directive comprehensive pregnancy options counseling, abortion services, adoption services, pregnant teen support services and others.
3. Create opportunities to involve the teen father or parents of teens in services when it is acceptable or appropriate for the pregnant teen.

b Advocate for direct services to teen parents to be made a priority in state funding allocations and in requests for federal funding.

1. Increase funding and support for comprehensive teen parent programs which may include drop-in centers, parenting classes, child care, and self-advocacy training, child birth classes, support groups, therapeutic groups, and teaching and tutorial services, employment and training, and housing programs.
2. Provide part-time surrogate support persons to the pregnant teenager and teen parent.
3. Provide peer counseling networks for pregnant and parenting teens.
4. Support the concept of coordinated case management systems to assure a range of social services to pregnant and parenting teens. This system will work best if it is voluntary for the teen.

Teen parents need to be encouraged to maintain and develop their own support systems among family, friends and local organizations. However, there may be times when a teen parent has a special or a temporary need that she cannot address by herself or with her own support system. There are also a large number of teen parents who do not have a supportive family to assist them. These teens have many needs which will require the help of social service programs. More programs are needed, distributed throughout the state, and existing programs need to be increased and expanded. The Task Force realizes that direct services to pregnant and parenting teens must be made a priority.

c Advocate for increased and improved child care for infants/toddlers and children of teen parents.

1. Develop more licensed child care centers that include infant/toddler care.
2. Assist new and current child care programs through aggressive search for broader funding sources including in-kind sources.
3. Promote the availability of parent instruction and parent support activities in all child care programs by assigning the responsibility to new or existing personnel.
4. Support voucher systems that will enable teen parents to purchase child care services directly from an approved provider of their choosing.
5. Encourage local child care providers to apply for the State of Maine child care license by offering incentives and benefits to all licensed providers.

   The licensing process helps to insure quality and safety in child care services.
6. Promote child care services that provide respite care for teen mothers for periods of time over 1 day and up to 3 days. This service could be provided through foster

families, surrogate grandparents, or infant/toddler group homes. This service should be promoted as a healthy, natural choice with no punitive effects on the teen parent.

7. Endorse and work to implement recommendations of the Maine Child Care Task Force (Report entitled: Child Care in Maine: An Emerging Crisis, November, 1984).

Infant/toddler and child care is a major problem for all of Maine's parents due to a lack of available services and the ever-increasing expense of the service. Teen parents, especially single females, are further burdened by limited financial resources and lack of transportation for utilizing services. The need for flexible child care services may also be greater for the teen parent because of the lifestyle that may include difficult and changeable schedules of schooling, part-time work and appointments with service providers. The Task Force understands that the expense of child care, the low wages for providers and the inability of parents to pay for child care is a complex and circular economic problem. These recommendations are made with the understanding that additional public and private funding sources need to respond to the desperate need for child care in Maine.

d

Improve interaction between teen parents and social service providers.

1. Seek and hire personnel who have demonstrated particular skills and success in working with teenagers.
2. Provide pre- and in-service training to front-line workers for the following issues:

   a. Adolescent development and sexuality, communication skills with teens, special needs of teen parents.

   b. Specific skills of providing information and referral for teens.
3. Examine policies and procedures which assure that the teen population is not being excluded or discouraged from utilizing services. Include specific plans for outreach to teens and program policies for teen mothers.
4. Work with the Departments of Human Services, Mental Health and Mental Retardation, and Educational and Cultural Services to develop and implement contract guidelines for agencies that interact with teens and teen mothers to include a written plan which addresses the special needs of their clients who are teen mothers. The plan may include direct services or a referral mechanism. Those programs providing services for counseling, substance abuse, domestic violence, sexual abuse and child abuse are of particular concern.

e

Advocate for increases in AFDC and other income supplemental programs and for an automatic annual cost of living adjustment to those programs.

Teen parents are ill equipped for employment and are often completely dependent on state financial assistance. The teen parent with one child supported solely by AFDC receives a cash payment of $289.00 each month; yet rents alone in many areas of the state average $300.00.

f

Advocate for improvements in the availability of transportation to teen parents.

1. Support the efforts of the Department of Transportation to study and recommend improvements in Maine's public transportation system that would provide more geographic distribution of the public transit system.
2. Support the efforts of the Department of Human Services in developing and funding a voucher system to assist low income clients in purchasing necessary transportation particularly in regions where public transit is otherwise unavailable.

Transportation is a major problem for most teens. The additional responsibility of transporting children and the further disability of poverty make transportation a nearly insurmountable obstacle for many teen mothers.

g Initiate the development of appropriate affordable housing alternatives for pregnant and parenting teens.

1. Encourage the Department of Human Services and private service providers to develop foster homes that are able to house both mother and child. The Department of Human Services should study and recommend changes in policy and statute that currently make it difficult for a teen to request foster care.
2. Promote residential living centers for pregnant teens and teen mothers and their children that allow for semi-independent living and on-site supervision to foster a secure learning environment for both teen and child.

The housing need of the pregnant and parenting teen can be a special problem. Her need for help with her child may be in direct conflict with her need to live independently. The Task Force supports a variety of housing alternatives to assist parenting teens.

h Implement and advertise counseling services statewide designed to meet the needs of pregnant and parenting teens.

1. Recognize and respond to the special needs of adolescents by providing appointments quickly, at flexible hours and at geographic locations accessible and comfortable to teens.
2. Utilize teen employees in these services when it is possible and appropriate.
3. Develop services for teen parents which are specialized for assisting:

   a. Married teen parents to create a healthy marriage and to become good parents.

   b. Unmarried teen parents, living alone or with a partner, to create a healthy relationship and to become good parents.
4. Create parenting classes, birth classes, and peer support programs for all teen parents regardless of socio-economic background or participation in other programs.
5. Provide follow-up counseling and support for teens who have chosen abortion or adoption to help to resolve grief, guilt, feelings of inadequacy or other emotional outcomes which may be part of the experience.

"My parents never talked to me about sex. I'm a boy and I guess they thought I knew everything,... I was in the eleventh grade before I got anything from school."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

i Include the teenage father (or the father of the teen mother's child regardless of his age) in services and policies.

1. Plan for program policies that invite and encourage the males to participate.
2. Support the efforts to make teen males aware of economic responsibilities whether they marry or not before they unintentionally become fathers.
3. Develop support groups and education for fathers to participate in the parenting of their children. The male, whether he is actively parenting or not, is a person with special needs. He often suffers isolation and a sense of blame. There are few role models for him to use as guidance in the development of his new role. He also is likely to be excluded from a relationship with his child in part because he is unable to fulfill other paternal obligations.

j Support accessible and appropriate adoption services for teens.

1. Advocate for and participate in a comprehensive study of State, licensed agency and private adoption procedures.

   a. The study should include the development of regulations for private, also known as independent, adoptions with particular attention paid to:

      1. Providing supportive services to adoptive parents;

      2. Completing adoption studies of the prospective adoptive couple prior to the filing of a petition for adoption;

      3. Encouraging the use of attorneys for and by birth parents under the age of 22 including probate court payment for attorney's fees;

      4. Assessing ways to provide financial support to birth parents during the pregnancy and for birth costs.

   b. The study should review state licensed adoptions with particular attention given to:

      1. Encouraging licensed adoption agencies to consider varying forms of open identification of adoptive and birth parents.

      2. Revising regulations to enable adoption agencies to use legal risk placements. These place infants directly into prospective new homes while awaiting the legal adoption process instead of placing the infant into a temporary foster home.

2. Increase education and information programs about adoption procedures.

   a. Clarify misconceptions and address negative attitudes about adoption.

   One of the prevailing attitudes is that keeping a child is an act of love. For some youth, it may be more of an act of love to select adoption, as a way to provide a better life for their children than they can currently provide.

   b. Implement marketing efforts to educate the public about available adoption services.

   The target audiences are pregnant teens, parents, educators, school counselors, health and medical professionals, counselors, youth program staff, other service providers, and the community at large.

3. Provide on-going counseling services for teen parent(s) who choose adoption. Provide support, grief and adjustment therapy, and referrals to other needed services.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

BIRTHLINE
Bonney Eagle High School's Peer Group
Community Women
Division of Maternal and Child Health Public Education Effort
DuSable High School Health Clinic
Family Planning—Clinic System
Family Services Integration Demonstration Project
Family Services Program
Genesis
Good Samaritan
Maine Child and Family Learning Center
Maine Children's Home
Male Adolescent Program
Parenting Education through Headstart
Parenting with Pat
Parent Resource Center and the Parent Connection
Parent Support Groups (See Diocesan Human Relations Services)
Portland Teen Health Program
Portland YWCA Teen Parent Services
St. Andre's
School Based Health Clinics
Somerset Adolescent Pregnancy Project
YWCA Intervention Program

"A number of parents do have strong values, but unfortunately do not take a firm enough stand by addressing the issue because of poor communication/listening skills hindering their parent/teen relationship, often closing communication completely."

ix. what can employers and the business community do for the pregnant and parenting teens?

a Provide jobs for parents by encouraging partnerships between public (government) and private (business) sectors to create employment and training opportunities for teen parents (See PREVENTION Section, IX.-Business, A.)

b Create policies which encourage entry level jobs with training and flexible work hours for teen parents.

c Increase the availability of work-based child care.

Maine faces a child care crisis with more demand than the current system—both private and public—can supply. Yet, studies show that workers' productivity increases and absenteeism diminishes when their child care arrangements are secure and of high quality. Teen parents are not exempt from the emerging child care crisis in Maine and would benefit from the involvement of industry in the child care solution.

The following programs are provided as ideas and examples to help you implement the recommendations in this section. Please see the "Idea Bank" located in the Appendix.

Child Care Connection
Cooperative Education
San Francisco Downtown Plan

x. what can government do to alleviate adverse consequences for pregnant and parenting teens?

a The Task Force recommends that local and/or state government:

Fund an array of services for pregnant and parenting teens and their children.

1. Social services, needed throughout the state, that must be created or expanded include: comprehensive teen parent programs, child care, parent aids, homemakers, education specific to teen parent issues, peer networks, and case management services. (VIII Social Services B.)
2. Health and medical services, needed throughout the state, that must be created or expanded include: advocacy to assist teens in managing their services, pre-natal, birth preparation, nutritional, pediatric, reproductive health care, and services housed together in an accessible location. (VII Health/Medical A, B)

"Giving birth to a child is the greatest thing on earth—but in marriage only. Giving birth in teen years without marriage and unable to take the responsibilities of parenthood is a deviation of natural and moral law and should be clearly condemned."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

b Initiate and fund services to provide for the counseling needs of pregnant teens as well as parenting teens.

Counseling services should include: non-directive comprehensive pregnancy options counseling, peer support; career adoption counseling; pre-marital and relationship or marriage counseling and treatment for sexual abuse, substance abuse and issues of self esteem. Responsibility: Department of Human Services. (VIII Social Services - A, B)

c Provide funding for and initiate the development of quality infant and child care in the public and private sector and school-based, to meet the needs of teen parents. It must have flexible hours, be affordable and geographically accessible. Responsibility: Department of Human Services. (VIII Social Service, C)

d Provide continued and increased funding for family planning and comprehensive reproductive health services to help teen parents avoid future unintended pregnancies and thus improve their ability to parent the children they already have. Responsibility: Department of Human Services. (VII Health/Medical, A)

e Develop and fund programs to provide alternative housing for pregnant and parenting teens and their children which may include foster homes, group homes, and semi-independent living centers and which will also improve access to other affordable housing. Responsibility: Department of Human Services. (VIII - Social Services, G)

"...programs that prevent or reduce kid problems make better financial sense to society than paying out to maintain these individuals with welfare checks, prison programs, etc. Human service programs are a good economic investment for society just as real estate, a good education or IRA accounts."

FROM THE PLURALISTIC SOCIETY
THE GOVERNOR'S TASK FORCE

f Insure that adequate transportation is available for teen parents and their children. (VIII Social Services, F)

1. Study and recommend improvements in public transit. Responsibility: Department of Transportation.
2. Develop and fund a voucher system to assist low income teens in purchasing necessary transportation. Responsibility: Department of Human Services.

g

Promote employment, training, education and career paths for teen parents with consideration of their needs for child care and for balance between training and working activities. Responsibility: Department of Labor, Department of Educational and Cultural Services, Department of Human Services. (IX Employers; IV Education)

A teen parent has an extreme need to have employment and training for two reasons. First, and most obvious, is that the teen must support a child. Second is that the teen is at a peak time to progress both in the academic world and in the world of work. If denied this opportunity because of the responsibility of parenthood, the teen may become permanently trapped in an impoverished lifestyle. The teen will find it increasingly difficult to join the labor force later in life. This effect of parenthood on employability can jeopradize both male and female parents. However, in reality, it is almost exclusively the burden of the teen mothers because most of them remain single and receive no support from the fathers of their children. This is a primary reason for the enormously disproportionate number of women and children who live in poverty.

h

Assist educational systems in developing and offering financial aid for post secondary education and training for teen parents. Responsibility: Departments of Educational and Cultural Services and Human Services. (IV Education, I)

i

Provide adequate basic financial assistance.

1. Increase AFDC and other supplemental programs and provide an automatic annual cost of living adjustment. (VIII Social Services, E)
2. Examine the federal regulation, known as the minor parent rule, to insure that this rule does not encourage teen mothers to leave the home of their parents.

A teen mother who lives with her parents may receive AFDC and medical assistance. However, her eligibility is effected by her family income. Some working poor families, whose income minimally exceeds AFDC guidelines, may need to encourage their teen daughter to live independently in order to receive the needed financial assistance.

j

Develop a special priority project for teen fathers to realize and accept their child support responsibilities and at the same time to continue their education thereby increasing their possibilities of success in the workforce. Responsibility: Department of Human Services. (IV Education, K)

Elements of the program shall include:

1. Aggressive and timely action to determine paternity and reasonable child support obligations.
2. Deferring a father's obligation to provide monetary support (as long as the father remains in high school with regular school attendance and is under eighteen) as a means to keep him in school so he can more ably provide for his child in the future.
3. Developing a joint effort with the Department of Educational and Cultural Services and local schools to monitor minors who are fathers and enrolled in school.
4. Using trained specialists in the field of adolescent development and sexuality, and domestic relations.
5. Utilizing teen fathers as speakers and peer counselors for other teens to inform them of the rights and responsibilities involved in parenting.
6. Developing an aggressive outreach and marketing program.
7. Conducting data collection for program planning and evaluation.

k Increase funding and therefore the capability of programs which provide comprehensive case management service to teen parents. (VIII Social Services, B.4)

l Implement a contract guideline which requires all purchase of service contracts for agencies that interact with teens to include a written plan for services or referral of teen mothers. Responsibility: Department of Labor, Department of Human Services, Department of Mental Health/Retardation, Department of Educational and Cultural Services, Department of Corrections. (VIII Social Services, D.4)

m Examine the child protective mandate in order to propose changes which would enable the Division of Child and Family Services (Child Protective Service) to participate in case planning and assessment of needs of a teen mother prior to the birth of an infant and prior to an abusive event in those situations where the behavior of the teen indicates potential jeopardy for the child. Responsibility: Department of Human Services.

n Study and recommend changes in policy and statute regarding placements and voluntary participation of teen parents in the foster care program. Responsibility: Department of Human Services. (VIII Social Services, G.1)

o Implement a comprehensive study of adoption including state agencies, licensed private agencies and private adoption procedures and work to revise regulation as recommended. Responsibility: Department of Human Services. (VIII - Social Service - J)

p Insure that Medicaid and other medical assistance programs are responding adequately to the specific needs of pregnant and parenting teens. The government should undertake a study of the Medicaid system in order to eliminate policies that may be discriminatory and to determine level of unmet health/medical needs among Maine's teen parents. Responsibility: Department of Human Services. (VII Health/Medical, F)

1. Work to provide a payment category for consultation and education with their health care provider.
2. Promote and publicize the available medical assistance programs, especially the Prenatal Care Program, with both the general public and the state workers who utilize and refer to that system to insure full teen parent utilization of those resources.
3. Encourage the Medicaid system to expand guidelines to create a bridge for working poor families to have temporary or partial medical coverage while they stabilize their financial resources.
4. Remove the service provider guideline which limits payment to social workers with a masters of social work degree in order to enlarge the available counseling community.
5. Assure that teen women who choose adoption for their child have equal access to the financial assistance programs that help pay for pre-natal and birth costs.

q Examine private health insurance policies to eliminate barriers to teen parents which prohibit adequate coverage. Responsibility: Department of Human Services. (VII Health/Medical, F)

explanation of minority votes

In accordance with the Task Force's commitment to acknowledge the diverse views of its members, the following information is offered in explanation of minority votes. There are several recommendations in the report that did not receive unanimous support. The reader is referred to this section to better understand why the vote met opposition. We believe that an understanding of the differences represented here, may help Maine citizens to work toward the common goal of preventing teen pregnancy and parenting in Maine.

There are two major areas of non-agreement represented below:

Position One addresses chastity, the role of parents, school based clinics, abortion and sex eduation.

Position Two addresses Medicaid funding for abortions for low income teens.

POSITION ONE: Neil Michaud, Diocesan Human Relations Services, Portland
Sr. Theresa Couture, St. Andre's Home, Inc., Biddeford
Reverend Thomas Davis, Littlefield Memorial Baptist Church, Rockland

preliminary remarks

The purpose of this section is to highlight the strong convictions held by the undersigned which differ from certain assumptions and recommendations that appear in the text of the Report.

Throughout its deliberations, the Task Force members were very sensitive to the fact that the issue of adolescent pregnancy and teenage parenting would be extremely controversial. In the Public Forums and its own meetings, the Task Force encouraged the surfacing of the pluralistic views which prevail in the community-at-large. The expression of the differences in this section is consistent with the openness of the Task Force.

In citing these differences and even opposition, the undersigned do not in any way wish to convey the impression that they are denigrating the overall Report, nor other members of the Task Force. In fact, the undersigned are in general agreement and have supported the greater portion of the recommendations. Considering the diverse backgrounds of the members, we believe one of the major accomplishments of the Task Force was its ability to reach a 100 percent consensus with most of the recommendations. All of us owe a debt of gratitude to Reverend Richard Sheesley, the Chairman, and a dedicated staff of the Department of Human Services for their outstanding work in behalf of the Task Force and its members. This should demonstrate to others that pluralism can serve to help mobilize communities to respond to this major social issue.

It is our prayer that the readers, from all walks of life, teens, parents, churches and those in government who promulgate public social policy, will do whatever they can to help alleviate this pressing problem. To do otherwise, is to continue the human tragedy of our children begetting and caring for children.

The observations and recommendations which are inconsistent with the values of the undersigned may be categorized as follows:

1. Abstinence and Chastity vs. Sexual Activity
2. Parents vs. Community/State Responsibility
3. School Based Clinics
4. Respect for **All** Life
5. Values, Sex Education and Unbiased Counseling

1. abstinence/chastity vs. sexual activity

The undersigned operate under the assumption that the majority of teenagers in Maine choose chastity over sexual activity. We are of the opinion the Report does not adequately emphasize this particular point. Several sections give the impression that most of Maine's adolescents are sexually involved. We contend that the larger number of our adolescents, although they experience social and inner turmoil, are capable of moving through this period of their lives without chronic sexual activity. Nor, do the undersigned necessarily wish to classify teenagers who may have had a single experience as being "sexually active."

Secondly, we further believe that there are many parents who are quite capable of imparting to their children and adolescents a clear set of values which upholds fulfillment of sexual activity within the dignity of marriage and intact family life. They hold this value as the ideal and preferable social and/or religious more.

It is recognized parents may not always be the perfect role model. In fact, too frequently they fall short of reaching their own ideal. Conceivably, the quality of communication and relationship with their offspring may not reach the desirable paradigm established by professionals. However, we still contend that perhaps in their own bumbling or awkward ways they do succeed to convey that chastity prior to marriage is the desired mode of life.

The Report, in our estimation, does not sufficiently recognize teenagers and parents who uphold, as a critical value, that sexual intimacy should be reserved for marriage. We believe the report should have provided them more extensive encouragement and praise regarding the importance of that value.

Having expressed this viewpoint, the undersigned wish to emphasize this **does not mean** that our members of the Task Force therefore, encourage or condone sexual activity among teenagers. Our overall deliberations would indicate the delaying of such activity is preferable. However, we believe the Task Force as a whole was reluctant to recommend integrating such activity within the context of marriage. The undersigned are convinced unless adults are direct with their own stance how can we expect our children and teenagers to receive clear messages which will influence their decision making process?

The undersigned maintain that much more needs to be learned from those teenagers who are able to say "NO." We should seek to understand how they arrive and sustain that decision to the same degree we search the dynamics which motivate those who are sexually active.

Similarly, our search for solutions should place more emphasis on dialoguing with parents who have helped and succeeded with their children and adolescents to look forward to meaningful sexual fulfillment within the context of the marital bond.

It is our viewpoint the report is skewed toward the sexually active teenager. As such, the accompanying danger is that the readers may interpret the emphasis on sexually involved youngsters as representing the universe of teenagers in Maine.

The undersigned believe the report should have made a clearer distinction between teenagers who come from Functional vs. Dysfunctional families. Certainly, children and youth are more vulnerable to departing from the ideal cited above if their crucial years of development are within families which cope with alcoholism, mental illness or severe economic or other stresses generally associated with the dysfunctional family. It is likely that these adolescents require more assistance from community resources many of which are recommended in the report. However, we feel strongly we must avoid the danger of concluding that all families and teenagers are unable to function adequately.

The undersigned wish to congratulate and praise those teenagers who select to preserve sexual activity within marriage. We wish to also inspire those parents who uphold this same value and encourage them to assist communities and other parents in their struggle with adolescent pregnancy and parenting.

We are confident our colleagues on the Task Force would agree we all have much to learn from your representative group of teenagers and parents who hold this value to be the way!

2. parents vs. community/state responsibility

The undersigned agree to a great extent with their colleagues on the Task Force regarding the role and function of government as defined in the report. However, we have clear-cut differences of opinion of the function of government beyond it serving as a catalytic body when it comes to addressing the issue of adolescent pregnancy. Education is seen as part of government.

The difference centers around the principle of subsidiarity, which essentially calls for the smallest unit of society to assume responsibility for social issues and/or problems. If the smallest unit is unable to carry on the duties then the next level has the responsibility to assign resources which will enable the other unit to function more efficiently and adequately.

Based on this principle, the undersigned strongly believe it is the parents who have the primary responsibility for educating their children and adolescents on sexual matters, not other social institutions.

Regardless of the adverse pressures and forces which impinge on today's family, we believe it still represents the basic unit of our society. As such, it is within the family where unity, love and values are nurtured. It is within this small community that bonding and strong relationships with others develop, which are generally on-going from birth until death.

Community and state resources should see their respective roles as providing assistance to those parents who require it and only when they encounter difficulties in discharging their responsibilities. We believe the report does not emphasize that social institutions should avoid usurping the inherent rights and responsibilities of parents.

Obviously, in certain circumstances, such as in child abuse, direct intervention will be necessary, but these should be viewed as exceptional rather than the rule.

The undersigned believe the observations and recommendations in the report do not adequately stress the primary role of parents regarding the education of their children and teenagers in the matter of sexuality. In many of the sections the emphasis seems to be on community resources, be it the schools, community and state agencies, to develop a variety of programs which would assume such responsibilities, thus running the danger of creating greater family disunity rather than harmony.

This is observed in recommendations regarding the value of local Action Councils and sections which specify the availability of services without parental consent. The first fails to adequately emphasize the primary role of the parents and the second, even though available by law, will in many cases, unnecessarily divide the parent-teenager relationship.

The above-mentioned observations should not be construed to mean other members of the Task Force minimize the importance of parent involvement in the sexual development of their children and adolescents. We know they share our view that parents are the primary educators. We contend, however, that the report could have more extensively highlighted this significant factor.

3. school based clinics

The undersigned are inalterably opposed to recommendations in the report to establish school based clinics regardless whether they do or do not dispense artificial contraceptives. There are several reasons for this opposition:

School based clinics would further erode the basic and primary mission of schools: education of our children and youth. Various studies of our educational system have repeatedly demonstrated that greater effort must be made by our schools to fulfill their primary mission.

The opening of clinics can only convey the image that our schools are becoming primary health, welfare and social agencies; that they are becoming isolated communities within communities which try to meet the total needs of children and youth entrusted to their care. Some propose that the clinics would be independent of school administration. The fact that it would be lodged within a municipal building cannot help but be seen as an integral part of the system. We believe such clinics will detract from the basic mission of the school.

We recognize, along with our colleagues on the Task Force, that schools and educators have an important role to undertake in helping to meet the needs of teenagers, particularly those who may be sexually active or parenting.

It is our recommendation that they be trained in the knowledge of community resources. This can be accomplished through regular orientation in their workshops. We would ask teachers to establish a positive but professional relationship with their students and whenever possible with their parents. Where appropriate referrals should be made to community resources.

Realizing a large classroom may render it impossible for a teacher to individualize each student or to become totally familiar with resources, therefore, all schools should have a community liaison person, such as guidance counselors who are capable of working with students, their parents and the community agencies.

School based clinics, in the view of the undersigned, would directly undermine the values of parents who have counseled their children and youth that sexual intimacy should be reserved for marriage. Even if parental permission were a condition of use, we believe such procedures generally become perfunctory, such as the signing of a form. Nor does the report sufficiently indicate whether or not contraceptives would be dispersed by the clinics. Even suggesting such clinics in the Families section contradicts the principle that parents have the primary responsibility for their children and teenagers on sexual matters. We believe the clinics would be divisive to the parent-child relationship.

The presence of school based clinics would convey primary emphasis on sexuality as being a health and medical issue rather than a value ladened one, which incorporate familial and personal relationships.

Such clinics, in our estimation, could falsely indicate or even mislead the students to believe that the educational institution condones sexual activity; that it is an approved public social policy.

Furthermore, such clinics would send a mixed signal to children and youth who choose not to be sexually active. They would find no support in their decision to maintain their chastity if school officials supported the presence of clinics and many of their co-students found it a "fun" place to go.

4. respect for all life

The undersigned totally disagree with all recommendations in the report which call for comprehensive and reproductive health programs and clinics which (even by implication) would incorporate the promotion or actual termination of life in the womb (abortion) and the dispensation of contraceptives to children and teenagers as part of their services.

We concur totally with our colleagues on the Task Force that "No human life is illegitimate." Given the desire on the part of the Task Force to upgrade the human dignity of adolescents caught up with premature sexual activity, pregnancy and parenting, the undersigned were disappointed and totally disagree with portions of the report which would directly or by implication select to terminate life in the womb. We find such recommendations contradictory to the concept and belief that all life is important and to be treated with dignity.

Although in the introduction to the Parenting Section, the Task Force indicates that it neither rejects or accepts abortion, recommendations were adopted, **with the undersigned voting in opposition**, which essentially could imply the promotion of abortion. The undersigned specifically oppose any action which would lead to termination of life in the womb.

In a number of instances, recommendations are advanced which specifically avoid the term abortion. However, in the deliberations of the Task Force clarification provided indicated a large portion **of those present** meant to include abortion in such services. This is particularly so with all sections which refer to the provision of "comprehensive reproductive health services."

Having stated our position, we also recognize, by present law, abortion is an alternative which is available. The facts substantiate that, although regretably, many teenagers choose this approach to cope with their pregnancy. We neither condemn nor judge those who make this choice.

We fully concur with our colleagues on the Task Force that sensitive post-abortion counseling should be available and existing services augmented in behalf of those teenagers.

5. values, sex education and "unbiased" counseling

The undersigned have already expressed that the primary responsibility for sex education rests with the parents. All social institutions, particularly schools, should promote and highlight this as a fact. Social institutions should do whatever is possible to help parents assume this responsibility.

Sex education sponsored by schools should be a course of last resort rather than the primary thrust. To do otherwise runs the risk of jeopardizing parental functions. Where courses on sex education are deemed necessary, parents should be carefully included and fully involved in the planning, implementation and evaluation phases so as to assure a broad spectrum of values reflected by families.

The undersigned do not believe sufficient emphasis is incorporated in the recommendations which would call for extreme sensitivity to parents who uphold the value that sexual intimacy, marriage and family are an integrated and dignified part of one's life.

We are deeply concerned that sections of the report (observations and recommendations) which accentuate the importance of contraceptives and abortion as a way of avoiding pregnancy will be interpreted as condoning sexual activity. We realized this may not be the intent of our co-members of the Task Force. However, the absence of the Task Force taking a specific stance on what it holds up as an ideal model, leaves a void and room for misinterpretation.

The undersigned are deeply convinced that there do not exist truly "objective," "unbiased" or "non-directive" approaches among those who address sexual development or activity or lack of it. We believe it is practically impossible for educators, professionals, parents and other significant persons to avoid conveying their own values regarding such subjects. Either through words, nuances, facial expressions, and other body language one's own preference will surface. In fact, frequently, the adult placed in a helping position will be asked directly by the participant where she or he stands on certain issues. The answer given will generally have some direct influence on the participant's decision making process.

For this reason, the undersigned believe strongly that greater involvement of parents should have been highlighted in the report and that unilateral action by professionals and schools should be discouraged. We further believe that the family value system from which adolescents' values emerge should have been given greater credence in the overall report.

In concluding this overall section we wish again to express our deep gratitude to all our colleagues and the staff of the Department of Human Services who worked diligently with us. We reiterate the fact that there were only a few instances regarding the scores of recommendations which the Task Force collectively advanced where sincere disagreements could not be resolved. In some instances, the differences centered on the degree to which some aspect was or was not sufficiently highlighted. In some others, there were unresolved issues, which with more time, perhaps could have been worked through. If some of our presentations appear to misconstrue or unfairly represent the perceptions of our co-members, we wish to indicate this was not our motivation.

It is our contention that generally speaking the Governor, the Commissioner of the Department of Human Services and the citizens of Maine should be proud of the accomplishments of the Task Force. All of us undertook the challenge of studying a very controversial and most complex issue. The undersigned believe officials at all levels and most importantly teenagers in Maine will truly benefit from this dynamic report.

POSITION TWO:

Margaret Pruitt Clark, National Organization for Women, Brunswick
Jeanne Bailey McGowan, Family Planning Association of Maine, Augusta
John Serrage, M.D., Department of Human Services, Augusta
Raymond Cook, Auburn
David Birch, Department of Education & Cultural Services, Augusta
Donna Bailey-Miller, Education Consultant, Wayne
Sabra Burdick, Department of Human Services, Augusta
Sharon Hole, Parent, South Harpswell

medicaid funding for abortions for low income teens

The undersigned members of the Task Force, acknowledging that abortion is a legal right for all women, disagree with the omission of a recommendation initially supported by a majority vote of the Task Force, which supports funding abortions for poor teens.

It has been estimated that approximately 630 Medicaid-eligible women between the ages of 15 and 20 will become pregnant in 1986. If similar to the general teen population, almost 2/3 or approximately 420 will receive financial assistance for the pregnancy option they choose; 210 who have chosen abortion will not. The State provides financial assistance to teens who give birth and parent their child through the Medicaid and State Prenatal Care Program. Eligible teens who choose abortion do not receive financial assistance for the pregnancy decision.

The 210 poor teens face particularly difficult problems. Access to basic medical services should not require a compromise of human dignity. Often, in order to raise funds for an abortion a teen may need to steal, deal drugs or prostitute herself or at best trade off limited funds available for food or shelter. Forcing young women into such circumstances, contradicts every recommendation made by the Task Force which seeks to enhance the teen's self-esteem, health and well-being.

The Task Force was charged with "suggesting improvements in programs and policies and related areas of service delivery, coordination, administration and evaluation." (Original Charge). It is the opinion of the undersigned that to NOT recommend funding for all necessary services fails to address the needs of pregnant teens who are in poverty.

a budget for teen pregnancy and parenting

The Task Force has said that while it is not government's **role** to define morals for families, it is government's **responsibility** to assist in preventing unwanted pregnancies by responding to those who are sexually active and to provide leadership to reduce the adverse effects of teen parenthood.

It is impossible to measure the cost in lost human potential when a teenager becomes a parent, but there are high socio-economic costs which can be measured. Governments at all levels share the burden of teen pregnancy and parenting in welfare and family support expenditures. Nearly 50% of the women who receive AFDC had their first children as teenagers. Moreover, Medicaid pays for the hospital delivery costs for teen mothers, pregnancy related health complications and the health problems of the babies born to teenagers. In addition to physical problems, teen parents are at higher risk of mental health problems and are more likely to become a child abuse and neglect referral. Low self-esteem, unrealistic expectations, isolation, ignorance about child care techniques, low levels of education, successive birth of children, high rates of unemployment and low level of occupation and family income are all traced to severe health, social and economic problems of teen parents.

It is estimated that in Maine more than 60 million dollars in public funds are spent on responding to the problem of teenage pregnancy and parenting in just one year. Yet, this is a conservative estimate that does not include all of the substantial schooling costs and most of the social costs which are necessary for high risk infants and children with special needs and handicapping conditions.

Although these are high annual costs, the effects of teenage pregnancy can last a lifetime and involve not only the teens and their families but their children as well. Teenage mothers have nearly twice as many children as older women. These children often continue the cycle of family instability and welfare dependency, and become pregnant themselves at an early age.

The Task Force believes that Maine must make an investment in the future of its children; an investment in prevention and an investment in reducing the adverse consequences faced by teen parents. Then, and only then, can we be secure in knowing that the next generation of children will make healthy decisions and become successful, productive adults.

It is the recommendation of the Task Force that an annual investment of 10 million dollars in new state funding be allocated to the teenage pregnancy problem in Maine. This represents just one sixth of the current expenditures which largely go to respond to the needs of teenage parents without providing them with adequate support and guidance to make concrete changes in their futures.

The goals for this investment would include a reduction in the incidence of teenage pregnancy as well as helping teen parents to raise healthy children.

Funds should be spent both through local programs which are part of an organized community response and also as part of a statewide effort within a framework of government leadership and community action.

Among the programs requiring new and additional dollars are prevention initiatives designed to:

- build individual self-esteem
- improve job, career and life aspirations
- provide opportunities for economic success
- increase decision-making skills
- provide accurate information
- offer clear messages to youth and improve parent/child communication
- improve family relationships and the skills of parents
- involve males through helpful, positive action
- promote positive peer influence
- offer surrogate adult role models
- conduct public education activities and engage the power of the media in developing healthy images

Services that are essential to build healthy, secure families in which children can learn and grow, avoid premature parenting, and to support teen parents in their challenging new roles include:

- primary health care
- reproductive health services and contraceptives
- economic assistance such as AFDC, medical assistance, jobs and job training
- family supports such as child care, parent aids, transportation, housing, case management and advocacy, and education and counseling

Services must be available, accessible and affordable, making available skilled workers, (including teachers), who are trained in sexuality issues and the special qualities and needs of adolescents and their families.

An organized community response should build on existing, successful efforts and develop new, innovative approaches. State leadership should be provided to examine, plan and conduct public education activities to improve the quality of life for teens.

Within this framework for prevention and response, the following budget outlines how these state funds can best be spent. The Task Force believes that it is also the responsibility of the federal government, municipalities and private individuals and corporate donors, as well as local businesses to share the costs of prevention and services to teen parents.

(Budget items are referenced to Section X: What Can Government Do?, Part I and Part II. The Government section represents the initiatives and actions called for in the family, teen, community, education, clergy, media, business, health/medical and social services' sections of the recommendations. For more detailed information refer to these sections. These initiatives require government responses as facilitator, enabler, funder and planner — all vital aspects of a successful community response to children, adolescents and their families.)

outline for $10 million annual investment (state dollars) to prevent adolescent pregnancy and parenting (part I) and to minimize the adverse effects of teen parenthood (part II)

x government		
	community development	
A, Part I	Local Action Council Development Statewide	$ 300,000
	education	
D, Part I	Statewide Public Education Campaign on adolescent development, parenting education and parent-child communication	250,000
E, Part I A, Part II	Parenting Skills Education and Support Groups for parents, teens and teen parents	400,000
M, Part I	Teacher Training for teachers of Family Life and Sexuality Education	100,000
L, Part I	Training for health/medical and social services personnel who work with teens and their families	100,000
	employment	
G, Part I G, Part II	Jobs and Employment Learning Opportunities for teens and teen parents	250,000
	health and medical care	
C, Part I A, Part II	Primary Health Care for non-Medicaid and non-insured families. Includes preventive care for all families with children, and pre- and post-natal care, birthing costs, and pediatric care for teen parents and their children	400,000

K, Part I D, Part II	Reproductive Health Care for teens and teen parents	400,000
J, Part I	School-Based Comprehensive Health Care	150,000
P, Part II	Birth Costs for Medicaid eligible teens who choose adoption	5,000
	social services, family support and economic assistance	
H, Part I	Peer Counseling and Peer Support for teens and teen parents	150,000
I, Part I A, Part II	Adult Surrogates, Role Models and Support Persons for teens and teen parents	50,000
C, Part I A, Part II	Family Supportive Social Services for children, youth and their families. (parent aides, homemakers, education and counseling activities)	350,000
B, Part II	Counseling Services Options, pre-, post-marital, parenting and relationship, career and family problem counseling	500,000
A, Part II	Comprehensive Teen Parent Programs	300,000
	Child Care Assistance	
F, Part I	School Based for teens as a learning experience and for teen parents.	300,000
C, Part I	Community based (For families with Children)	500,000
A, C, Part II	Teen Parents	800,000
K, Part II	Comprehensive Case Management for Teen Parents	150,000
E, Part II	Alternative Housing for Teen Parents	600,000
F, Part II	Transportation Assistance for Teen Parents	200,000
J, Part II	Child Support Enforcement and Education Project for Teen Fathers	50,000
C, Part I I, Part II	Basic Financial Assistance 10% increase in AFDC payments for children and their families including Teen Parents	3,500,000
	state based activities	
N, Part I	Comprehensive Information and Referral System	80,000
O, Part I	State Councils Cabinet Level Council Task Force Implementation Council	36,000
P, Part I	Statewide Media Impact Group	36,000
S, Part I	Statewide Conferences for Parents	18,000
Z, Part I	Study of Sexual Activity Among Maine Adolescents	10,000
O, Part II	Study of Adoption	15,000

studies, advisory committees and councils

The Task Force struggled with the difficult issue of teen sexuality, pregnancy and parenting for many months. The Task Force goal was to provide guidance and recommendations in a way that would encourage immediate changes and response on behalf of teens. At times the information to consider was overwhelming. At other times, there was not enough information or data available to make concrete recommendations. In several areas of deliberation the Task Force recommended that a committee or council be convened or a study be undertaken to further explore and provide leadership on specific issues. For your information we have included the following items, referenced to the specific recommendations in the text.

prevention

1. Convene Local Action Councils throughout the state to provide leadership and develop local action plans for the prevention of adolescent pregnancy and to reduce the adverse effects of teen parenting. Prevention, III Community, A.I.
2. Develop parent advisory groups for curriculum development and/or a controversial issues committee to assist with the implementation of comprehensive health education including family life and sexuality education. IV Education, A.6
3. Explore the interest in and support for school based clinics; examine the availability of comprehensive health services; examine issues of parent involvement, parent's rights, teen rights and the unmet health needs of teens. IV Education, G.I.
4. Convene a statewide group appointed by the Governor to explore the impact of the media on children and youth and to advise, encourage and initiate healthy images in the media. VI Media, A.
5. Study the cost of health care and methods to finance care including the Medicaid system, to identify barriers to the delivery of health care for teens and teen parents. VII Health and Medical, B.6.
6. Establish, by Executive Order, a cabinet level council consisting of the Commissioners of Human Services, Labor, Educational and Cultural Services, and Mental Health and Mental Retardation to maintain adolescent pregnancy prevention as a state priority. X Government, O.1.
7. Appoint an Implementation Council to oversee and report on the implementation of the recommendations of the Governor's Task Force on the Prevention of Adolescent Pregnancy and Parenting. X Government, O.2.
8. Assign a Legislative Committee to review the Maine labor laws which serve to limit the ability of adolescents to acquire meaningful employment. X Government, T.
9. Design a study mechanism which will collect and analyze data on adolescent sexual activity in Maine for proper program planning and resource allocation. X Government, Z.
10. Conduct research and gather data on male pregnancy prevention practices, knowledge and attitudes. Special Section, Males.

parenting

1. Examine private (health insurance) and public (Medical Assistance) programs to reduce financial barriers for quality health care to teen parents. Parenting, VII, Health/Medical F.
2. Study and recommend improvements in public transit in Maine to insure that adequate transportation is available for teen parents and their children. Parenting, VIII, Social Services, F.
3. Study and recommend policies that make it difficult for a teen to acquire a foster home for herself and her child. Parenting, VIII, Social Services, G (1).
4. Conduct a comprehensive study of adoption including state licensed and private adoption policies and procedures. Address support services to adoptive parents and birth parents, open identification procedures and legal risk placements. Parenting, VIII, Social Services, J.1.